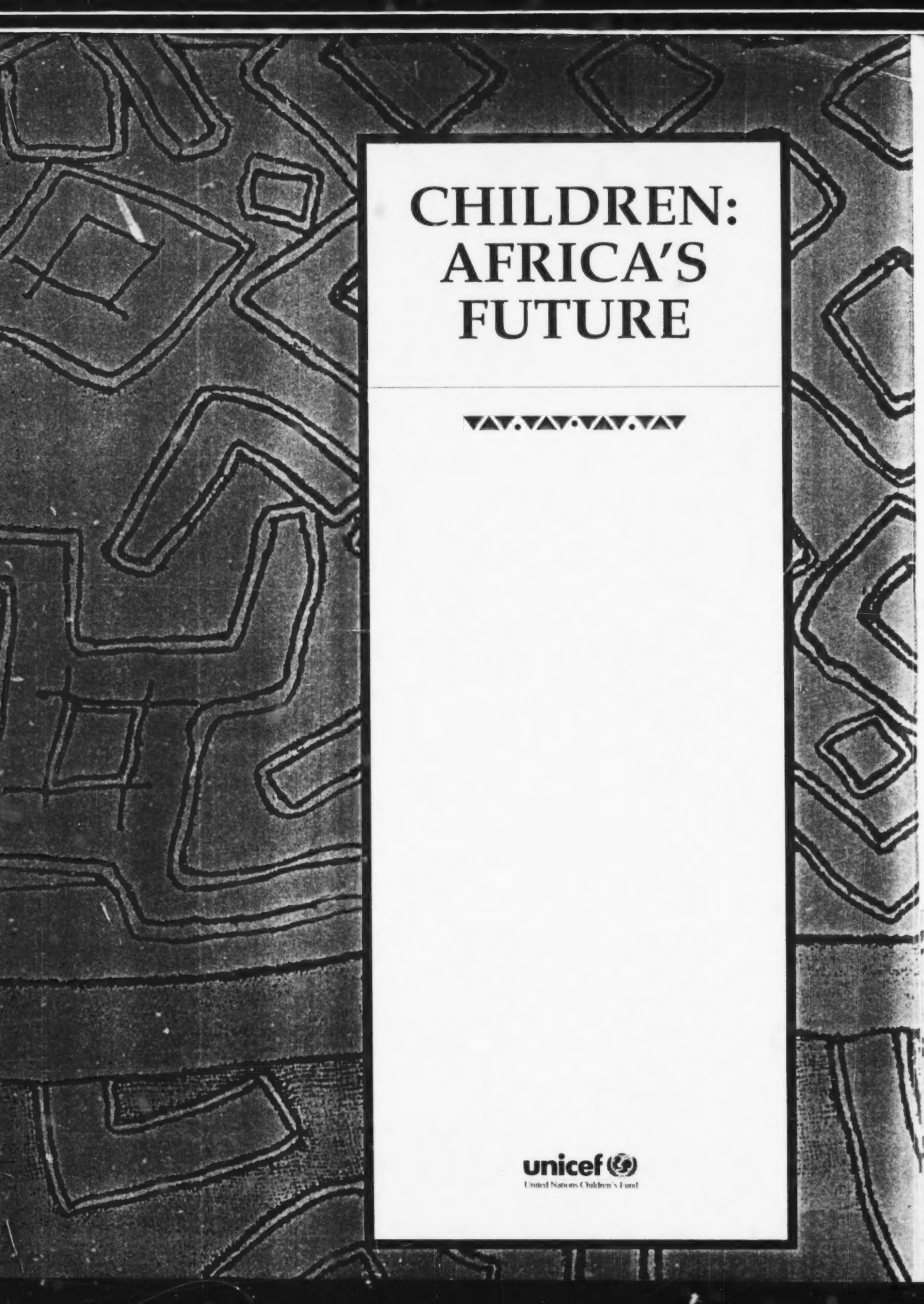

CHILDREN: AFRICA'S FUTURE

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United Nations Children's Fund

Contents

Day of the African Child: 16 June 1991 ..... *(355 words)*

A day of promise for the African child — Statement by James P. Grant, Executive Director of the United Nations Children's Fund (UNICEF) ..... *(814 words)*

Overview ..... *(945 words)*

An African commitment to child rights ..... *(757 words)*

Getting to know the African child ..... *(1180 words)*

Debt relief for child development ..... *(1201 words)*

Children: 'zones of peace' ..... *(887 words)*

Children in difficult circumstances ..... *(1020 words)*

Child immunization ..... *(1113 words)*

The Bamako Initiative ..... *(957 words)*

Education ..... *(1104 words)*

The girl child ..... *(1078 words)*

Food and nutrition ..... *(955 words)*

Water supply and sanitation ..... *(1018 words)*

Urbanization ..... *(995 words)*

Children and AIDS ..... *(1042 words)*

Reports from the field (vignettes)

Mobilizing for immunization in Sierra Leone ..... *(485 words)*

A major health improvement ..... *(707 words)*

Africa's AIDS orphans ..... *(1043 words)*

Mobilizing Tunisia ..... *(542 words)*

Managing village water supply ..... *(615 words)*

Day of the African Child: 16 June 1991

Scores of countries in Africa and elsewhere will host a variety of special events this month in commemoration of 16 June as the 'Day of the African Child'.

The 'Day', which was declared in a resolution of the 51-member Organization of African Unity (OAU) last July, is to be an annual event which gives Governments, non-governmental organizations, international agencies, media, the general public, and children, in particular, a special opportunity to focus on the needs of Africa's children and the steps which are being taken to meet those needs. The date — 16 June — has been chosen in commemoration of the massacre of Soweto children in June 1976.

This information kit has been produced by UNICEF as a partner in those efforts to secure the survival, protection and development of Africa's children. Its contents are designed to be used as a general reference to issues affecting the welfare of children, or as news features which can be reproduced by the media or by non-governmental and other organizations in their newsletters and other information materials.

The kit is 'solutions-oriented'. It identifies the urgent needs of many millions of children on the African continent today, as well as the obstacles to their delivery. But it also documents improvements in health and other indicators of progress to demonstrate that African nations can achieve, and are already approaching, important goals towards providing a better future for their children.

UNICEF and OAU have encouraged African nations to prepare their own special programmes to mark the day. The events they have planned range from Children's Parliaments to cultural and sporting events.

Many countries, with the support of national organizations and institutions, have signalled their intention to use the occasion as a means of reaffirming their support for the Declaration and Plan of Action, which resulted from last year's World Summit for Children. That historic event set major goals for child health, education and welfare to be met by the year 2000. The 'Day of the African Child' this year, and in years to come, will provide a benchmark against which the delivery of those promises can be measured.

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Children: Africa's Future

Statement by James P. Grant, Executive Director of the United Nations Children's Fund (UNICEF), on the occasion of the Day of the African Child

A day of promise for the African child

The Organization of African Unity has signalled its hopes for the future by declaring 16 June to be the 'Day of the African Child'. The declaration reaffirms the commitment of Africa's leaders to the survival, protection and development of the region's single most important resource.

This special event will mean different things to different people. For some, it will be a cause for celebration, an opportunity to report progress on promises which have been made to Africa's children. For others, it will be a time for reflection on hardships visited once again this year on the region's youngest and most vulnerable citizens. There is progress and tragedy enough on the African continent today to justify either or both approaches.

The Day of the African Child represents a challenge to adult society in Africa and beyond to address the immediate and future needs of every African child: a challenge embodied in the Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, and the Declaration and Plan of Action adopted at the 1990 World Summit for Children. African leaders have accepted the moral obligations towards children contained in each of these documents.

The obstacles to child survival and development in many African communities today, however, are formidable. Population growth continues to outstrip Africa's current capacity to feed its children. Prolonged economic crisis, aggravated by staggering foreign debt and low commodity prices, has led to deep cuts in the social programmes which are essential if children are to lead full and productive lives. Drought has cast its shadow on the lives of 27 million Africans this year, and armed conflicts continue to hamper efforts to relieve the suffering. More than 20 million Africans were estimated to be victims of war-related famine in 1990 alone; as always, the majority of these were women and children.

Nevertheless, progress has been possible in the face of adversity, and the future for most African children today is brighter than it was for their parents and grandparents. The improving fortunes of many of Africa's children can be traced to the progress that has been made in the delivery of three basic services in particular: immunization, water supply and sanitation, and primary education, as well as to a greater political will to address child-related problems.

The drive for universal child immunization has meant that nearly all African countries have established accelerated immunization programmes to combat the main child killer diseases. The countries of northern Africa have achieved almost 80 per cent vaccine coverage for children before their first birthdays, while protection against diphtheria, whooping cough, tetanus, polio and measles has reached almost 58 per cent

of children in the same age group in eastern and southern Africa. Eighteen out of 44 countries south of the Sahara reached targets of 75 per cent coverage in 1990.

Over the past decade, access to safe drinking water increased from 83 per cent to 87 per cent in urban centres, and from 33 per cent to 42 per cent in rural areas. Urban sanitation coverage rose from 65 per cent to 79 per cent, and from 18 per cent to 26 per cent in the countryside.

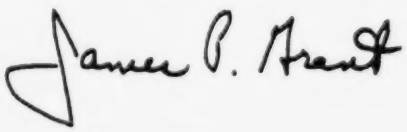
Although primary school enrolment and the quality of education slumped towards the end of the 1980s under the burden of economic crisis in sub-Saharan Africa, enrolments had risen dramatically during the 1970s from 65 per cent to almost 90 per cent for boys and from about 44 per cent to almost 69 per cent for girls.

Accompanying these developments has been a steady rise in life expectancy from just 41 years in 1960 to 53 today. The under-five mortality rate has been cut by almost 45 per cent during the same period.

It is imperative that the international community provide Africa with the additional assistance it needs to help itself out of the crisis and back on the development path. The difficult yet necessary adjustments and reforms being made in Africa in order to stop the backward slide and return to growth will not be enough; debt relief, increased aid flows and other international interventions are needed to avoid a downward spiral toward catastrophe.

UNICEF has been a partner in Africa's development efforts, more than doubling its financial support for child survival and development initiatives in the region over the past decade. This commitment is expected to grow as countries give increasing attention to new challenges such as AIDS, safe motherhood and the needs of the girl child.

The Day of the African Child encourages us to reflect on the hardships and challenges ahead. The horizon, in many ways, is bleak. But we should also take stock of the many important gains that have been made against painful odds. They are a reminder that promises made to our children can be kept.



James P. Grant
Executive Director

Overview

To many observers, the African child is a composite of misfortunes: a symbol of hunger, ill health, illiteracy and other manifestations of poverty. The impression can be overwhelming, but it is also grossly misleading. Examples of deprivation abound which have been widely documented and disseminated on film and in print. But an unrelenting focus on Africa's hardships and emergencies, to the exclusion of much else, distorts the larger picture.

Africa's diversity defies packaged images of its children. The continent embraces 51 countries with a wide range of economic possibilities, from those of the middle-income oil exporters to low-income oil importers. Access to essential services and opportunities for advancement also vary markedly within countries, between economic and social groups, between rural and urban populations and between the sexes. The girl child is at a particular disadvantage in societies that give their sons the best of whatever is available.

The widely varied prospects for Africa's children, ranging across a richly patterned geographic, climatic, cultural, linguistic, economic, rural and urban landscape, should be warning enough that there can be no stereotypical African child. The scope of the continent is so vast that attempts even to average statistics can cloud reality.

Not all of Africa's children are starving, and the vast bulk of what they eat is grown or produced in Africa.

Not all of Africa's children are on the knife-edge of survival. Under-five mortality has been reduced by 42 per cent since the 1960s. During the same period, average life expectancy has risen to 53 years, an increase of 12 years.

Not all of Africa's children are illiterate. Primary school enrolments rose dramatically during the 1970s and averaged almost 90 per cent for boys and 69 per cent for girls by 1980.

These figures are low when compared with data from the industrialized world, but progress should be measured against the past. It has taken Africa just three decades to raise health, literacy and other standards to levels which industrialized civilizations took more than a century to achieve.

The big picture for Africa is one of progress and, in some cases, dramatic gains produced by national commitments to a wide range of basic health and other services for children.

African nations were among the first to ratify the Convention on the Rights of the Child last year, and they have followed up with an African Charter on the Rights and

Welfare of the Child. Africa's leaders were universally supportive of the 1990 World Summit for Children, and they have reinforced the Summit Declaration and Plan of Action by declaring an African Decade for Child Survival, Protection and Development.

The practical expression of these long-standing concerns can be seen in:

▲ immunization programmes in every country to fight diseases, including tuberculosis, measles, diphtheria, whooping cough, tetanus and polio;

▲ nutrition programmes for infants, small children and pregnant women to offset the incidence of low birth weight and to provide nutritional supplements including vitamin A to combat nutritional blindness; iron to curb anaemia; and iodine to prevent goitre, cretinism and other impairments;

▲ programmes to control diarrhoeal diseases by providing access to safe drinking water and sanitation facilities, and to treat diarrhoeal dehydration;

▲ policies that support basic education and ensure equal access to schooling for girls as well as boys.

The frequency of natural and man-made disasters has impeded progress in these areas in many countries. Twenty-nine of the world's 42 least developed countries are in Africa, where their peoples generally lack the resources to cushion violent fluctuations in their fortunes. The economic crisis of the 1980s, accompanied by crippling external debts and structural adjustment programmes, forced deep cuts in social spending with all too predictable results. Prolonged military conflicts have complicated the picture for many countries. War-related famine affected some 20 million Africans in 1990 alone.

Progress in the region has also been affected by the pace of social change and new challenges. Rapid urbanization and the AIDS epidemic have overtaxed already slender resources in many countries. AIDS is already the leading cause of death in Abidjan (Côte d'Ivoire), and rates of infection among adult populations in other cities including Kampala (Uganda), Kigali (Rwanda) and Bujumbura (Burundi) are approaching 30 per cent. One in every 10 people infected with AIDS in East and Central Africa today is a child under five years of age.

Most Africans still live in rural communities, but populations of urban areas are expected to double over the 15-year period 1985-2000. Some of the new urban immigrants have achieved higher standards of living, but the flight of many millions of rural people to towns and cities has overtaxed services and existing infrastructure and left many of the newcomers worse off than before. The horizon for children living in these growing metropolises can be vastly more complicated than it was for their parents. The number of children living off their wits on the streets of African capitals has grown alarmingly in the past decade. While many children are drawing on the advantages of modern infrastructure and services, others are suffering the social dislocations familiar to more modern societies — homelessness, exploitation and abuse.

For Africa's children — rural and urban, male and female — the future is a mixed bag: a future filled with uncertainties as well as opportunities. Obstacles to the development of Africa's children span the full range of social services. But in country after country, hunger, illiteracy and ill health have yielded when the political commitment of Africa's leaders to the needs of their children has been strong. Progress has not been as swift as nations would want, but there is abundant evidence that it is finding its mark.

An African commitment to child rights

Sixty per cent of all Africans are children — a fact that has exercised the minds and imaginations of the region's lawmakers and politicians to a particularly high degree in recent years.

Dr. A.N.D. Koroma, a parliamentarian from Sierra Leone, reflected those concerns recently in a presentation to UNICEF in New York: "Africa has one of the youngest and fastest-growing populations in the world, and the highest number of child deaths annually", he said. "It is the only continent where this number is projected to continue increasing into the 21st century."

Dr. Koroma noted that child abuse and neglect, and the inadequacy of existing legal, socio-economic and institutional remedies had combined with armed conflict and natural disasters to inflict great hardship on millions of African children. He noted, however, that in African culture the child remained 'a special gift from God' and an occasion for great celebration. "Furthermore, Africa has a tradition of cohesive family life and a strong system of child care and protection based on family and clan."

Dr. Koroma's comments have special relevance in the light of two major developments for the region's children in recent months.

The first is a powerful African endorsement of the Convention on the Rights of the Child which became international law on 2 September 1990. And the second is the drafting and adoption by the Organization of African Unity (OAU) of a special African Charter on the Rights and Welfare of the Child.

The Convention, which so far has been ratified by more African countries than by any other regional group of nations, established the child's right to every available means of survival, protection and development as well as the right to participate in decisions affecting his or her situation. It covers a wide range of rights that the child should enjoy as an individual and addresses civil and political rights as well as social, economic and cultural rights.

The Charter restates those fundamental objectives while taking to heart the uniqueness of Africa, its traditions and cultural values. It is the first regional instrument to be based on the Convention.

During the decade-long drafting of the Convention, OAU members underlined the urgent need to give special attention to the needs of children through a Declaration on the Rights and Welfare of the African Child (1979) and the later Declaration (1989) that the 1990s should be the Decade for the Survival, Protection and Development of the African Child. In 1988, the African Network for the Prevention and Protection against

Child Abuse and Neglect (ANPPCAN) held a workshop in collaboration with UNICEF for African experts in Nairobi, where the drafting of an African Charter was recommended to complement the Convention's provisions and tailor it to the specific situation of children in the region. African legal experts and social scientists held a preliminary drafting session in August 1989, and a draft Charter was adopted by heads of State and Government at the 26th Summit on 9 July 1990.

Among the Charter's 48 articles are provisions to:

▲ give children a voice in administrative proceedings affecting their situation;

▲ ensure the right to free basic education, health care and equality regardless of ethnic, tribal and religious differences, or sex;

▲ give disabled children special measures of protection and access to services;

▲ establish minimum ages for admission to employment and protect children against work-related and other forms of abuse;

▲ ensure justice before the courts consistent with the child's dignity and worth;

▲ ensure that adoption procedures are in the best interests of the child and protect against trafficking or improper gains from intercountry adoptions;

▲ protect the family and ensure the equality of men and women within the family unit;

▲ protect the child against harmful social and cultural practices;

▲ establish 18 as the minimum age for marriage and make the registration of all marriages compulsory;

▲ protect children against recruitment to participate in armed conflict.

Unlike the Convention on the Rights of the Child, the Charter also defines responsibilities that the child should have to family, society and the State.

The Charter also provides for the establishment of a Committee of Experts which would, among other things, monitor implementation of the Charter, promote the rights it sets forth and receive reports from individual States on their efforts to comply with its provisions. The 11-member Committee would also be open to receive communications in confidence from individuals, groups and non-governmental organizations, investigate matters related to the Charter and publish its findings.

The Charter will come into force 30 days after its ratification by at least 15 Member States of OAU.

Getting to know the African child

Of the estimated 640 million people in Africa, about 47 per cent are children under 16 years of age. Their average life expectancy is 20 years less than that of children in the industrialized world and some of the reasons are abundantly clear.

A little more than half of all the children have access to health services. Over 80 per cent of those in urban areas and over 40 per cent in the rural areas have safe water to drink, and about one in four of those below five years of age is underweight. Almost 60 per cent have been immunized against the six most threatening diseases.

Among the survivors, about three in ten of the school-age boys and four in ten of the girls have had very little or no primary education — a factor which severely handicaps their prospects of rising above their parents' situation.

At first glance, these are not very promising numbers, but they also tell only part of the story. Progress must be measured against the past.

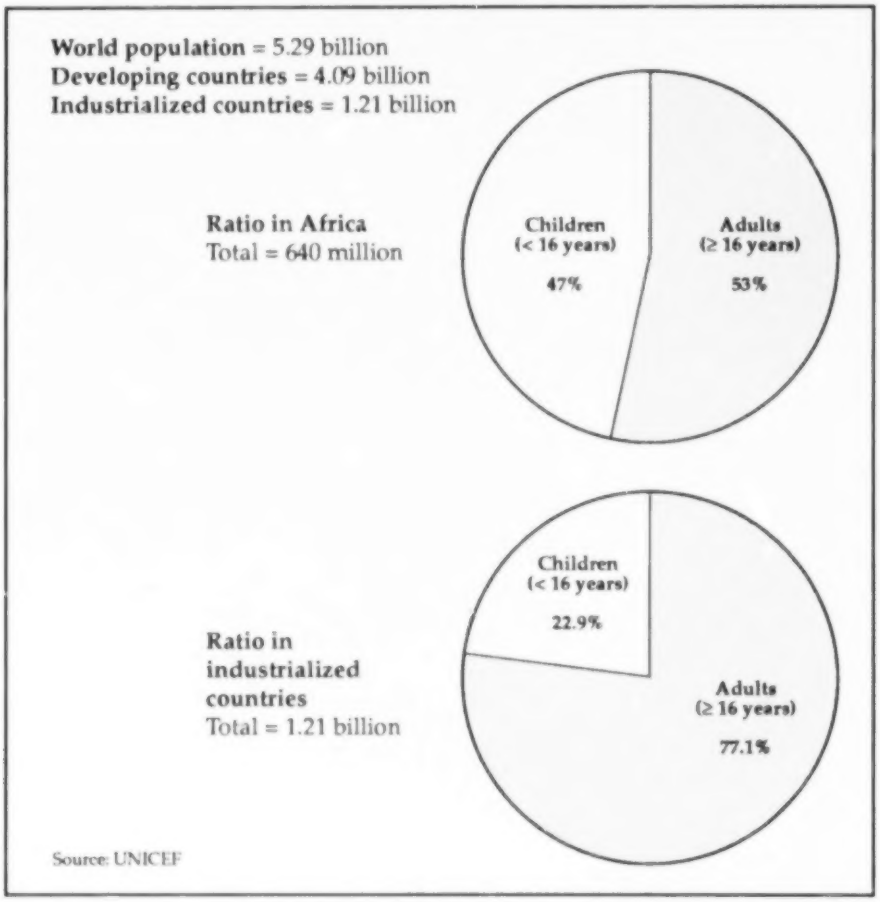
In 1960, average life expectancy in the region was just 41 years, with more than one in four children dying before age five. Average life expectancy for children born in 1990 has risen to 53 years. The mortality rate for children under five is still high in comparison with the industrialized world, but five in every six children born in Africa this year will survive the first five vulnerable years.

It as a similar story with education. Although primary school enrolments in Africa fell several percentage points for boys and girls under the weight of the economic crisis between 1980 and 1987, enrolments rose dramatically in the 1970s from about 65 per cent to almost 90 per cent for boys and from about 44 per cent to 69 per cent for girls.

The broad regional picture of life for African children becomes more difficult to focus, however, as one steps beyond well-chosen sets of data. While there is evidence from scattered studies that the economic crisis has also impacted negatively on child nutrition, the data is inadequate to determine whether the situation overall is actually deteriorating or improving. Although a little more than half the region's child population has access to health services, the definitions of health services and access to them vary widely between countries. One in seven babies is reported to weigh less then 2.5 kilogrammes at birth, but this data covers only those babies recorded by health systems. The limited access of millions of people to safe drinking water is a major concern, but assessments of 'safe' are often rudimentary, and water that might be safe at the source can be at high risk of contamination from excreta and other wastes in urban areas and in low-income communities in particular.

Added to these gaps in knowledge is the difficulty of knowing just how much

Child population vs. adult population, 1990



worse things might have been if certain communities and nations had not performed well in the face of extraordinary economic hardships beyond their control. How much higher might Africa's child immunization rates have been if GNP had grown at the rate of other developing regions? Per capita GNP for all developing countries rose by an average of nearly 3 per cent a year from 1965 to 1980 and by more than 3 per cent between 1980 and 1987. Although per capita GNP increased for Africa as a whole between 1965 and 1980, it has since fallen by an average of more than 2 per cent per year.

The frustration for most statisticians working with data from Africa today, however, is that the more they get to know about the situation of the African child in 56 national settings, the more apparent become the gaps in their data, and the more questions they have.

The causes of these limitations are largely historical. The collection of comprehensive and reliable statistics is dependent upon sound infrastructure and well-trained personnel. But before independence, data collection in many African countries was somewhat crude and tied mainly to the economic interests of the external powers. Statistical production rose markedly with the emergence of newly independent states in the early 1960s, but there were few African statisticians. Data gathering was heavily dependent upon expatriates, who, for the most part, used statistical concepts which had been developed for a different socio-economic setting.

The 1970s brought a consolidation of data. There were censuses in most countries, and an African Household Survey Capability Programme (AHSCP) was initiated to build local capacity to gather timely information on changing social and economic conditions.

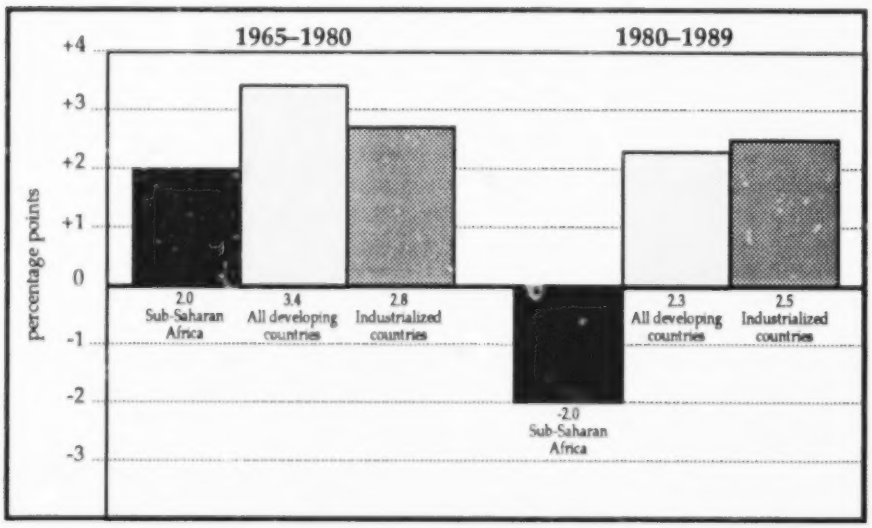
During the oil crisis of 1973 and the painful economic restructuring of the 1980s it became clear, however, that important data needed for economic planning were still weak or non-existent. The most obvious shortcomings were in the areas of health, where administrative data related to only a small part of the population; agriculture, where estimates of the production of food were unreliable; employment, where information on employment by sector was weak and very little was known about the unemployed; income, where expenditures were used as a substitute for a lack of data on income; transportation, where data systems had not kept up with changes in modes of transport and data was weaker than 30 years earlier; and trade statistics, where the records of trading partners outside of Africa were used in preference to locally produced statistics.

Partly in response to these deficiencies, specialized ministries and agencies started their own statistical services, often in competition with national statistical offices. Although this sometimes benefited individual users, it loosened national coordination of data collection and often wasted scarce resources. The economic crises of the 1980s also cut into budgets for data gathering, and at the beginning of the 1990s most African countries still had not achieved a balanced and sustainable flow of quantitative information.

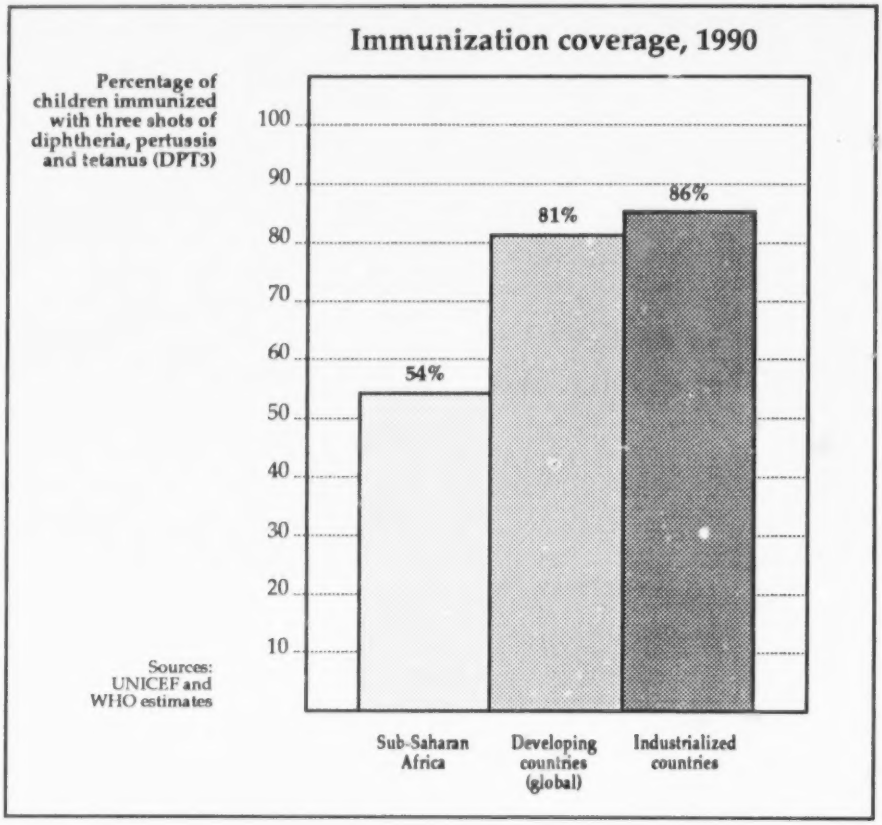
Two positive developments, however, suggest that renewed emphasis may be placed on getting to know the African child better.

The first is the extraordinary success of the universal child immunization (UCI) programme, which targeted 1990 as the year in which coverage against tuberculosis, polio, measles, tetanus, whooping cough and diphtheria could be achieved for 80 per cent of the developing world's children. That goal has been achieved, and although sub-

Real gross domestic product (GDP) per capita



Source: *World Development Report*, World Bank, 1990



Saharan Africa remains at the low end of the target scale, the region's gains have been spectacular. Immunization coverage in Africa overall has increased from less than 20 per cent at the start of the 1980s to almost 60 per cent today.

The targeting of UCI goals involved careful monitoring of progress and reliable records. Those involved in the programme noted that, while data was sparse and of rather poor quality at the beginning, growing demand led to a more timely collection of information along the way. With feedback and use, the quality of the data improved greatly.

The second major stimulus to statistical gathering was the 1990 World Summit for Children, which adopted 27 goals for the 1990s. A key element of the Summit Declaration and Plan of Action was the agreement of all the signatory countries to develop data systems for the close monitoring of progress. African nations were among the first to put their weight behind the Summit and its goals.

Debt relief for child development

For more than a decade the welfare of many millions of African children has been mortgaged against a mountain of debt.

Pressured by natural and man-made disasters, shrinking commodity export income and rising debt service payments, Governments have bowed to the demands of creditors for fiscal austerity embodied in the sometimes radical restructuring of their economies. Government payrolls, food subsidies and budgets for such basic services as health care, education, and water supply and sanitation, have usually suffered the first cuts, with the almost guaranteed result that the poorest and most vulnerable dependents — women and children in particular — would bear the brunt.

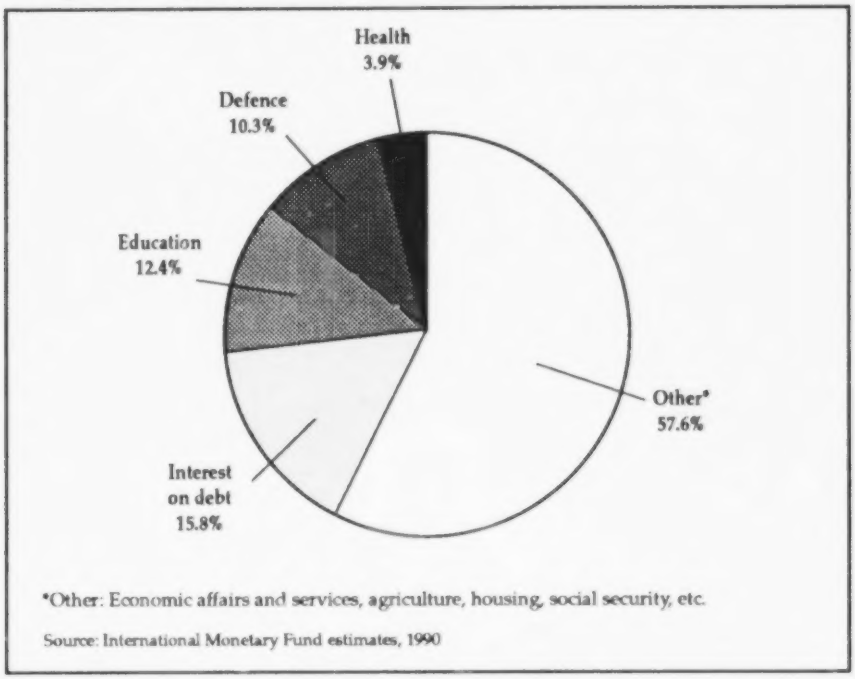
When the first painful human statistics came to light in the early 1980s, UNICEF urgently appealed for a reordering of priorities within national restructuring packages to protect social services. By mid-decade UNICEF's call for 'adjustment with a human face' gained ground as evidence of extreme social hardship in a score of countries mounted. But by the end of the decade, the economic and social situation of most African families south of the Sahara was worse than it had been at the beginning. Infant mortality rates, which had been falling in many countries for several decades, are now at a standstill, and literacy rates, which improved rapidly during the 1960s and '70s, are either frozen or in decline. Per capita expenditures in health and education are declining both in absolute terms and as a percentage of GNP. Africa has the highest average under-five mortality rate in the world and is the only continent where child deaths are projected to increase during the 1990s.

Although the concept of adjustment with a human face is now widely accepted, most responses have been little more than palliatives. New loans to Africa have dried up, development assistance has stagnated and debt relief measures have proven inadequate. If current trends are not reversed, Africa will have a 40 per cent share of the global infant and child death toll by the end of the current decade — up from 15 per cent in 1950 and 30 per cent in 1986.

The Economic Commission for Africa calculates that the region's debt last year was almost US$272 billion, up 4.7 per cent since 1989. Its interest payments on that money were equal to 34 per cent of the value of its exports — a sum double the size of its education budget and four times the amount devoted to health. In some countries those imbalances are even larger.

The World Bank attributes much of the increase to shifting exchange rates against the US dollar, but the trend is also a reflection of the limited impact of current debt relief strategies.

Average government expenditures in Africa as a percentage of total expenditures, 1985



*Other: Economic affairs and services, agriculture, housing, social security, etc.

Source: International Monetary Fund estimates, 1990

The United Nations Secretary-General's Special Adviser on the debt crisis, Bettino Craxi, told the General Assembly last October that the economic problems of sub-Saharan Africa would "seem insoluble without drastically reducing their debt and introducing exceptional concessionary measures by the International Monetary Fund and the World Bank". In 1989, sub-Saharan Africa's payments to the multilateral agencies accounted for 50.2 per cent of its debt service payments. This compared with 17.6 per cent for payments on official bilateral credits and 32.1 per cent on private debt. The combined interest bill for long term and IMF debt in 1989 was US$7.2 billion.

To place these numbers in a more human perspective, it is estimated that all UNICEF child-oriented goals for sub-Saharan Africa in the 1990s could be achieved with an additional US$7 billion a year. UNICEF has proposed that half that sum would come from national resources and an equivalent amount from foreign assistance. The net gain would be some 18 million young lives saved and an equal number of children spared the crippling disabilities and side-effects of childhood diseases.

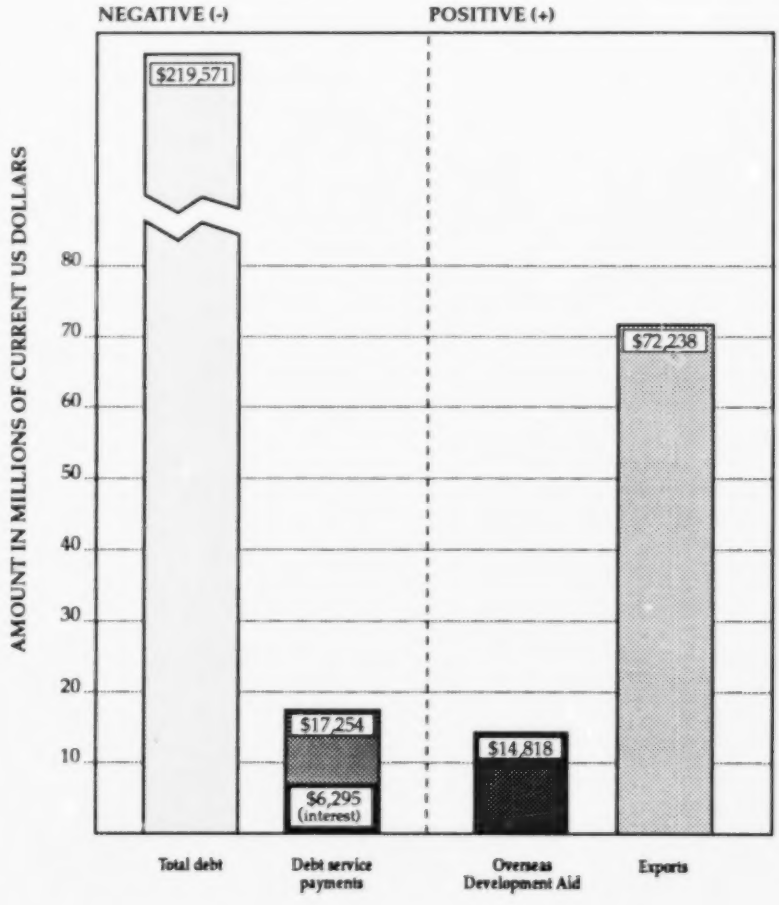
The most recent debt relief initiatives for the developing world at large are the 'Toronto terms' and the 'Brady Plan' which provide for some debt reduction through partial forgiveness. The Toronto terms were agreed upon by the seven major industrialized countries at their Toronto summit in June 1988 and concern the official bilateral debt of the poorest — mainly African — developing countries. They call for partial cancellation of principal, concessions on interest rates and the rescheduling of official bilateral loans. The Brady Plan, named after the United States Secretary of the Treasury, James Brady, was launched in 1989 and involves the guarantee and buy-back of commercial debt through a fund set aside by the World Bank, IMF, regional banks, the European Community and the Government of Japan.

Mr. Craxi maintains that Governments, multilateral organizations and commercial banks should all be involved in debt relief and that official aid flows from the industrialized countries should increase. One of his recommendations is that bilateral debt servicing payments should be converted into local currencies to finance development, environmental protection and human resource development. There is as yet, however, no clear movement to overcome the burden of Third World debt and to compensate for the lack of social sector investment.

Following its plea for adjustment with a human face, UNICEF has pursued a number of initiatives on 'debt relief for child survival'. It is considering several approaches to official and private debt.

With regard to official debt, it believes Governments and public or semi-public institutions should be encouraged to write off their loans, or if not, to convert

Africa's financial balance sheet, 1987



Source: *African Economic and Financial Data*, UNDP and World Bank, 1989

outstanding loans into grants, or to donate interest payments back to debtor Governments — all on condition that the beneficiary Governments make contributions in local currency to programmes benefiting children.

In the case of highly discounted private debt, UNICEF proposes 'debt for development' swaps. It believes commercial banks and other holders of these obligations should be encouraged to donate this debt to UNICEF in exchange for a contribution in local currency by the beneficiary debtor for programmes supporting children. For private debt with less discounted value held by commercial banks and donor Governments, it is proposed that National Committees for UNICEF and appropriate financial institutions should be encouraged to make funds available for the buy-back of debt on secondary markets, on the condition that the debtor Government contributes an agreed amount in local currency to programmes for children.

UNICEF has participated in six debt swaps for child development in Sudan that, in total, have generated the equivalent of US$2 million in local currency while reducing Sudanese debt by more than US$20 million. The returns to children have been in the areas of health, water and reforestation programmes in Kordofan, and discussions are in progress for similar arrangements elsewhere in Africa.

Another possibility, which is being explored with the appropriate international financial institutions, is the establishment of a social investment trust fund to be financed by government donors through bilateral and multilateral channels. The fund would make grants to debtor Governments so that they could buy back external debt in the secondary markets at substantial discounts. Terms and conditions would be negotiated individually. The beneficiary Governments would be required to contribute funds in local currency to social development programmes agreed to by the financial institution and UNICEF. It is envisaged that the fund would finance projects in the areas of basic health, nutrition, education, and water supply and sanitation, as well as for women's development and children in especially difficult circumstances.

Children: 'zones of peace'

In April 1989, years of bloody civil war in Sudan yielded briefly to a rather straightforward moral proposition. The proposition, made by UNICEF and other international agencies, was this: civilian populations — and children in particular — should not be held hostage to political and military objectives.

In the preceding year, some 250,000 Sudanese civilians — most of them women and children — died of famine related to protracted fighting between government troops and rebel forces of the Sudan People's Liberation Movement and Army (SPLM/A). The fighting, and the use of famine relief as a political and military tool, disrupted agricultural production and tightened a noose of hunger around civilian populations in garrison towns and rural areas.

Between 1988 and early 1989, UNICEF Executive Director James P. Grant made eight trips to Sudan as Personal Representative to United Nations Secretary-General Javier Pérez de Cuéllar to plead the case for 'corridors of peace', through which emergency relief supplies could be delivered to all civilians in need wherever they might be, including children and women corralled and starving within the battle zones.

After complex negotiations, the warring parties granted safe passage to Operation Lifeline Sudan (OLS), which has since delivered more than 192,000 metric tonnes of food and over US$20 millions worth of non-emergency assistance to more than 2 million people. In the spotlight of world opinion, OLS also allowed the leaders in the conflict to save face by averting mass starvation.

Working under the OLS umbrella, a coalition of international agencies was able to deliver essential drugs; to immunize children against the threat of epidemics; to establish emergency water supply and sanitation services; and to provide shelter and relief commodities as well as foodstuffs.

When the emergency persisted into 1990, the Sudanese Government asked that the OLS effort be continued in drought-affected parts of the country, in the southern conflict zones, in transitional areas, and in the capital, Khartoum, which had almost doubled its population as a result of refugee influxes.

Despite some early difficulties in 1990, parties to the conflict showed signs of increased flexibility towards OLS. Immunization coverage for children trebled in the garrison towns, and handpump programmes began to provide emergency water supplies to displaced persons in Khartoum and El Obeid.

The 1990 drought, however, was even more extensive and severe than the disaster of 1984-85. In the face of the resultant 1.2 million tonne emergency food aid

requirement and additional needs for non-food relief items, the United Nations Secretary-General launched a new appeal on 14 March 1991 for more than US$716 million for emergency assistance, including food aid, to cover basic health needs, water supply, sanitation and shelter for the affected populations. On 22 March, a fleet of trucks and trailers from the World Food Programme (WFP) carried 1,000 tonnes of maize from Kampala into SPLM/A-held areas, and in early April, an 11-truck convoy from UNICEF brought 90 tonnes of medical supplies, seeds and agricultural implements from Kenya into the south of the country. An estimated 7.7 million people are currently affected by the Sudanese emergency.

These life-saving runs, often at great risk to those who man the vehicles, have set a precedent for Africa, the importance of which cannot be overestimated. Ongoing emergencies, complicated by wars elsewhere in the Horn, in southern Africa and, most recently, in West Africa, also cry out for codes of conduct to protect the innocent in conflict situations. Implicit in these humanitarian agreements, tested as 'corridors of peace' or 'days of tranquillity' in Central America and in Lebanon during the 1980s, is recognition that while political leaders may come and go, the future of a nation ultimately hinges on the survival and healthy development of its children.

OLS has so far inspired similar agreements in Angola and Ethiopia.

A Special Relief Programme for Angola was launched on 2 November 1990, following agreements reached between the United Nations, the Government of Angola and the National Union for the Total Independence of Angola (UNITA), opening the door to emergency relief deliveries to all provinces severely affected by drought and war-related famine. Under the Programme, UNICEF is responsible for coordination and implementation of non-food activities, as well as the monitoring of non-food deliveries. The Programme agreement stipulates that humanitarian assistance by the United Nations is neutral and should be made available to all civilians in need without discrimination and wherever they are located.

In Ethiopia last year, an accord reached by WFP with the Government and the Eritrean People's Liberation Front opened the rebel-held port of Massawa as a supply source for some 2.2 million people in need of food aid in Eritrea. A 'Southern Line' supply route to drought-affected populations in Tigray and northern Welo was also freed by a Joint Relief Partnership designated by all sides of the conflict there to mount relief operations. This church-based consortium of relief agencies transported more than 100,000 metric tonnes of relief food to 18 distribution centres in the conflict zones. The Partnership also reactivated health facilities at nine health centres and two hospitals in Tigray and northern Welo with UNICEF support. WFP has estimated that more than 6.6 million Ethiopians — 2.6 million of them women and children — will need urgent relief assistance this year.

It is hoped that similar modalities establishing children as 'zones of peace' can be worked out for the delivery of relief supplies in Liberia and Mozambique.

Children in difficult circumstances

Wars and civil strife, natural disasters and economic recession have taken a terrible toll on Africa's children. Africa was home to two thirds of the victims of wars during the 1980s, and new unrest in West Africa has dampened hopes for a more peaceful outlook in the 1990s.

UNICEF has estimated that at the height of these conflicts, 25 African children were dying every hour from the effects of the fighting. Another 5 million continue to struggle for survival amid related economic distress, deteriorating social services and food scarcity. In southern Africa alone in the past decade, combinations of war, famine and the related trauma of broken health care and other services caused more than 1.9 million deaths — 1.2 million of them infants and young children.

Armed confrontations have now eased in Angola and Mozambique, the main regional flashpoints. Namibia gained its independence last year, but another six countries — Botswana, Lesotho, Swaziland, Tanzania, Zambia and Zimbabwe — also carry the scars of military raids or insurgencies directed from South Africa and remain burdened by excessive military defence budgets at the expense of social and economic development. All six have had to support refugee populations, and a seventh, Malawi, has had to contend with the needs of 800,000 refugees. All told, there were some 2 million refugees from war in the region during the 1980s and an additional 10 million displaced persons within Angola and Mozambique.

The number of children in especially difficult circumstances in Mozambique is estimated in the millions, including children who have been displaced, orphaned or separated from their families as a result of war. Others have been kidnapped for extended periods by bandit forces that have forced them into armed service or abused them physically and sexually. A recent study of 50 displaced children by the Ministry of Education found that all but eight of the children had lost a family member or been separated from their families. All had fled from bandit attacks at least once, 29 had witnessed a murder, including 11 who had seen or heard the death of a parent. Sixteen had been kidnapped or had lived in bandit-controlled areas, and all had experienced beatings, threats or starvation. This group is believed to be representative of children throughout the country today — an estimate that translates into hundreds of thousands of children who have been psychologically scarred by war-related violence.

The Government, with the support of Save the Children Fund, UNICEF and other groups, is training more than 1,000 schoolteachers to help children cope with their experiences through group activities. A family tracing programme is working to reunite children with relatives and to place orphaned children with substitute families. An emergency programme is also supplying food, seeds and hand tools to displaced communities to assist the country's early steps towards economic stability.

As thoughts have turned towards rehabilitation in southern Africa, however, millions of children and women remain captive to ongoing civil wars and conflicts affecting Djibouti, Ethiopia, Somalia and Sudan, and UNICEF recently added Chad, Liberia, Mali and Mauritania to its list of countries in need of emergency assistance.

UNICEF has focused on:

▲ emergency assistance for children and women in communities of refugee and displaced persons;

▲ rehabilitation programmes to help disabled and traumatized victims of war and natural disasters;

▲ the provision of basic services and infrastructure to help restore the productivity of poor families.

Among other highly visible victims of war and economic decline in the region are many thousands of children who can be found living and working on the streets of most capital cities.

In Abidjan, the numbers of children arrested on the streets grew fourfold between 1981 and 1986. In N'djamena, the police are reported to have rounded up neglected children in their thousands. The numbers of working and street children have also grown alarmingly in Kenya, Madagascar, Sudan and Zambia. UNICEF is supporting initiatives by non-governmental organizations and regional associations throughout the region to provide them with protection and services ranging from health care to education, shelter and job training.

One of the best-known groups tackling the street child phenomenon in Africa is the Undugu Society of Kenya. The Society was founded in 1975 to help the street children of Nairobi but has since expanded into city slum areas, confronting the multiple threats of drug addiction, prostitution and diseases such as AIDS with programmes providing shelter, education, employment and other support.

Fabio Dallape, former Director of the Undugu Society, says that many people underestimate the resourcefulness of children in difficult circumstances. He says that in areas of acute poverty and neglect children are in fact the resource and must be helped to discover and develop themselves.

"Unfortunately, many approaches appear to consider the street child as totally helpless", he says. Street children, Dallape says, want to learn and be educated. "They know how to survive and are used to a hard life. They are capable of organizing themselves. They have a great sense of solidarity among themselves and towards others who are poor. They are willing to do any kind of job and they are creative in their recreational activities." Mr. Dallape says that an understanding of the needs of children in difficult circumstances by local administrations, churches, police, voluntary agencies, schools and the community itself is vital to a better future.

"Street children associate themselves with certain geographical areas where they perceive resources to be available for their survival", he says. "A place to sleep undisturbed, a place to wash clothes, a place to take a bath, a place to look for food, be it only in the garbage cans, a place to provide services in exchange for some money, a place to make friends. These places are located in communities, and community members play an important role in helping street children to survive with dignity and, with external support, enabling street children to develop."

Child immunization

One of the great success stories of the past decade has been the rapid progress of African and other developing countries towards the immunization of children against diseases that kill and maim.

The delivery of highly perishable life-saving products — vaccines — to remote and previously inaccessible regions of the world is a story of extraordinary political will, community solidarity, management and organization.

Immunization has been practised for the past two hundred years. Vaccines to combat the main child killer diseases were discovered decades ago, but for financial, technical and other reasons, protection against those diseases was available to fewer than 20 per cent of the developing world's children as recently as 1980.

Successful immunization programmes are dependent on a number of factors including adequate infrastructure and an informed public. They also require that:

▲ facilities and technical personnel are in place to deliver timely vaccinations to children and mothers.

▲ vaccines can be stored and transported at low temperatures. Vaccines are not heat stable and lose their effectiveness if they are not refrigerated — a formidable obstacle to success in many developing countries, which must first establish a 'cold chain' linking modern medical centres with remote, traditional communities. A typical cold chain includes cold rooms, freezers, refrigerators, cold boxes and vaccine carriers, all linked together by an effective management system.

▲ syringes and needles are sterile and immunizations given by well-trained health workers.

▲ parents and community leaders understand and support the need to vaccinate children as early in life as possible in keeping with established schedules. For immunization to be effective, mothers must bring their children for several doses at timely intervals.

A major breakthrough for Africa and the rest of the developing world was the massive global immunization campaign of the 1960s and '70s to eradicate smallpox. The success of this programme, managed by the World Health Organization (WHO), led to an expanded programme on immunization (EPI) in 1974 to build on the knowledge and infrastructure created to fight smallpox. It was estimated in the late 1970s that some 5 million children were dying each year from six other preventable diseases — tuberculosis, measles, diphtheria, whooping cough, tetanus and polio — and that a major

programme for the provision of vaccination integrated in a primary health care package would be required to fight them.

In 1977 WHO challenged the industrialized world to support developing countries in a quest for universal child immunization (UCI) by 1990. The target varied by region according to the existing level of infrastructure, manpower and other support available for the job. It was defined globally as 80 per cent coverage of children by their first birthday for each of the following: one dose of BCG against tuberculosis; three doses of DPT against diphtheria, whooping cough and tetanus; and three doses of polio and one dose of measles vaccines, respectively. African Ministers of Health set their regional target at 75 per cent coverage.

By 1987 nearly all developing countries had established accelerated immunization programmes using a variety of strategies to improve immunization coverage. These strategies included national campaigns that mobilized community leaders, teachers and religious leaders; national immunization days with intensive media support; the development of health services which included immunization; and steps to identify and follow up on children and monitor their vaccination attendance to ensure full immunization.

The global average for immunization coverage in developing countries has increased almost fourfold from a low 20 per cent coverage in 1981 to almost 80 per cent today. At the end of 1990 BCG coverage had reached 89 per cent; polio and DPT were at 83 and 81 per cent respectively; measles coverage was 78 per cent; and tetanus toxoid coverage for pregnant women was 53 per cent for the second dose.

Asia and the Middle East and North Africa have achieved the highest levels for all antigens followed by sub-Saharan Africa and the Americas. Africa started from the lowest level of coverage and has required the most extensive development of its health infrastructure.

The Middle East and North Africa region had reached its 80 per cent goal by the end of 1990, with a regional average of 93 per cent for BCG, 85 per cent for the third dose of DPT and polio, and 78 per cent for measles. Tunisia, with a head start in terms of infrastructure, initiated a national campaign which quickly pushed coverage levels to almost 90 per cent.

Despite its low level of infrastructural development and extreme economic and social constraints, sub-Saharan Africa has made great strides towards its goals in the past five years.

The acceleration of immunization activities south of the Sahara had an auspicious beginning in 1984 with 'Operation Commando' in Burkina Faso where more than 1 million children were immunized in one three-week period. Campaigns followed in Senegal and the Congo, and a further push in 1986 came with the declaration of African Immunization Year by national Ministers of Health. Coverage for measles in the region at that time stood at 37 per cent.

By the end of 1990, the weighted regional average for three doses of DPT and polio and for measles in eastern and southern Africa had reached 58 per cent. And 12 out of 20 countries in the region had achieved their 75 per cent targets for 1990. By the end of 1990, all countries, with the exception of Kenya, Malaysia, Namibia, Uganda and Zimbabwe, had reached their targets. Angola, Ethiopia, Mozambique and Somalia reached high coverage in areas under government control, but nation-wide development efforts in all four of these countries have been severely disrupted by war and civil conflict.

Despite many difficulties, West and Central African countries have also made substantial progress towards their goals. At the end of 1990, seven countries — Cape Verde, Central African Republic, the Congo, Equatorial Guinea, Gabon, the Gambia and Sierra Leone — had reached 75 per cent coverage or better for all antigens. All have well-developed infrastructure and have managed to attain high levels of performance without special activities.

Global immunization efforts have had strong backing from an international coalition of Governments and agencies. In 1984 UNDP, UNICEF, WHO, the World Bank and the Rockefeller Foundation organized a Task Force for Child Survival, and UNICEF was a conduit for more than US$500 million for UCI programmes during the decade. UNICEF has been able to procure vaccines at low cost on behalf of Governments and support organizations such as Rotary International and has delivered more than 4.4 billion doses since 1982.

As a result of the drive for UCI, vaccination services are now perhaps the most widely available of all health-care activities in Africa and the rest of the developing world. And with these services in place, many countries are already looking to develop yet another level of health protection by adding services such as vitamin A supplements and health education for mothers when they bring children for their regular shots.

The Bamako Initiative

Africa's bill of health is currently the worst in the developing world. Health sector annual expenditures declined from US$5.16 per capita in 1975 to US$4.70 in 1985, and there appears little likelihood that Governments will be able to squeeze more from their budgets while economic restructuring continues. Half the population of Africa lives beyond reach of formal health services, and it has been estimated that by the end of the decade, sub-Saharan Africa, with only 11 per cent of the world's population, will account for almost 40 per cent of all deaths among children under five years of age.

Dire projections like these have convinced the vast majority of Health Ministers in countries south of the Sahara to rethink their approaches to health care. At a meeting of the World Health Organization (WHO) in Bamako, Mali, in 1987, they took the first bold steps towards a revival of primary health care focused primarily on the needs of children and women.

The Bamako Initiative, as it is now known, is an attempt to integrate a wide range of individual health interventions including child immunization, the control of diarrhoeal diseases, pre- and post-natal care, and the prevention and control of malaria, acute respiratory infections and AIDS. The Initiative is radically different from past approaches in that Governments have agreed to decentralize these services by entrusting their management and some financing decisions to district and community health centres. The expectation, already bearing fruit in a significant number of countries, is that even under difficult economic and social conditions, basic health services can be improved and made self-sustaining.

Working closely with WHO, UNICEF has raised more than US$21 million to help implement the Initiative, and 12 countries have so far embraced the strategy wholeheartedly. Another six are expected to join this core group during the year (1991), and nine others are well into the planning stages for future implementation.

As health expenditures have declined in Africa, the salaries of health-care workers have eroded to the point where many have taken part-time employment in the private sector or abandoned their posts altogether. No country can hope to preserve, let alone improve its services without a motivated core of health professionals, and a first priority for many has been to find ways of wooing these people back. Although the main responsibility for salaries under the Bamako Initiative still rests with Governments, countries such as Benin and Guinea have been able to retain significant numbers of health-care professionals by supplementing their salaries through community financing. Early experiences from a number of countries have shown that even poor households keep cash in reserve for medical emergencies.

In countries like Sierra Leone, where the poor have become accustomed to

paying exorbitant prices for unprescribed drugs from unqualified private suppliers, the focus of the Bamako strategy on the supply of essential drugs at affordable prices has been a boon. Indications are that families can, in fact, save money by purchasing their basic drugs through community health centres modelled on the Initiative. Their willingness to pay for prescribed medicines through well-supplied community outlets suggests that the distribution of unprescribed and sometimes dangerous products in much of the region simply reflects the failure of the formal health sector to meet public demand for better services.

Kenya has countered the distribution of non-prescription medicines by distributing essential drugs at fair prices through village pharmacies manned by trained community health workers. The pharmacies also sell insecticide-impregnated mosquito nets as protection against malaria and dispense condoms free of charge as protection against the transmission of AIDS as well as for family planning purposes.

Cameroon and Mauritania have followed the lead of Benin, Guinea and Nigeria in preparing protocols for the diagnosis and prescription of essential drugs, and the World Bank and the African Development Bank have supported a restructuring of the pharmaceutical sector with a view to developing local production. In the meantime, donors have been covering the cost of most essential drugs distributed by countries in the first year of the Initiative, allowing some to build holding funds in local accounts as a supplement to operating costs, including salary incentives for health workers.

A number of countries are exploring the Bamako concept of community financing for health services. With national health budgets frozen or in decline, a revival of basic health-care services seems unlikely unless the public is willing to share costs. UNICEF is supporting policy discussions on various options for Uganda and Zambia.

Although the Initiative was conceived primarily as a strategy to rebuild primary health care services in rural areas, Africa's urban centres are growing rapidly, and in the poorest urban sectors infant and child mortality rates are frequently higher than in the countryside. Increasing attention is being paid to the health needs of low-income urban populations, and Sierra Leone is emerging as a pioneer in this regard. Having adopted the broad framework of the Bamako Initiative as its national health policy for maternal and child health care, Sierra Leone plans to introduce it to Freetown, the capital.

Although funds remain desperately scarce, these and other experiences over the past three years have galvanized support for the basic concept of sustainable primary health care in Africa. In June last year, a Pan-African Conference on the Financing of Community Health Activities, organized by WHO's regional office for Africa in collaboration with UNICEF, brought more than 150 African health experts to Kinshasa to review their goals and approaches. There was general agreement that the financial footing for health services delivery in sub-Saharan Africa had been strengthened by community co-management of services and that the use of formal health services in the region was rising as the quality of affordable care improved.

Education

School enrolments and the quality of education declined in Africa as a whole last year. While wealthy industrialized nations spent more than US$6,000 for every student they had in school, the least developed African nations could only find as little as US$2 per child. In many countries, schools this year will be without books, paper, pencils or chalk for the blackboard, not to mention classrooms.

Africa is not alone in this regard. An international conference on Education for All, held in Thailand last year, was told that between 1972 and 1985, central government investments in education fell from 13.6 per cent to 7.6 per cent of the total budget of all low-income countries except India and China. However, Africa has more ground to make up than other developing regions. Some 60 per cent of Africans are illiterate.

On a recent list of 14 countries with illiteracy rates of 70 per cent or higher, the United Nations Educational, Scientific and Cultural Organization (UNESCO) counted 10 from Africa (Benin, Burkina Faso, Chad, Gambia, Guinea, Mali, Niger, Senegal, Sierra Leone and Somalia). And of nine countries with more than 10 million illiterates, two — Egypt and Nigeria — were in Africa.

The average rates for male and female illiteracy ranged from 88 per cent in Somalia to 71 per cent in Sierra Leone, but the wide disparity between the illiteracy rates for men and women was especially noticeable. In every country, women's illiteracy was above the average, ranging as high as 94 per cent in Burkina Faso.

UNICEF Executive Director James P. Grant made the point to delegations at the education conference that equality of opportunity for education was a life-and-death issue deserving top priority. Repeated experience has shown that when mothers are educated and understand the interrelationships between such things as safe drinking water, sound nutrition, personal hygiene, immunization and low-cost treatments for life-threatening illnesses such as diarrhoea, their children have a much greater chance of sound, healthy development.

"Literacy of women is the most important single factor in the reduction of child mortality", Mr. Grant said. "The children of more educated mothers have a greater chance of survival and healthy growth than those of the less educated or illiterate."

The education conference urged policy makers to restore investments in education to the status it enjoyed in the 1960s and '70s. The conference established a goal of primary education for all children by the year 2000 and cautioned nations against policies which pursued quantity at the risk of quality.

"Getting more children into schools is not enough", said Federico Mayor,

Director-General of UNESCO. "A primary school that graduates pupils who cannot read, write or solve simple problems has failed as a school. The quality of education provided in many Third World schools is sometimes so distressingly poor that even pupils who persist in schools for several years may never achieve an enduring level of literacy."

Against the backdrop of economic crisis in Africa, reasons for the recent decline of education are not difficult to find. A World Bank study in Guinea-Bissau reported that there were no guidebooks for teachers beyond the first grade. In Nigeria, in 1981 a student could enter teacher training with only five years of primary education. In Zaire, 46,000 teachers were dismissed as part of a 1984 austerity plan. This was 20 per cent of the national total. In Kenya, social spending was a priority between 1964 and 1973 and education expenditures grew by 15 per cent per year. But between 1974 and 1983 interest payments on external debt rose by 13.7 per cent a year and education expenditure fell dramatically. In Ghana, which had one of the most developed and effective education systems in West Africa in the 1970s, economic hardship caused educational expenditures to fall from 6.4 per cent of GDP in 1976 to 1.7 per cent in 1985.

Despite these inroads, however, a number of countries have reassessed their possibilities and embarked upon promising education recovery programmes.

Ghana announced a reform of its education sector in 1987 to expand access to primary education in low enrolment areas; to improve educational quality, efficiency and relevance to the country's needs; to make financing for education more equitable; and to strengthen the planning and administration of the system. The reform programme has the support of the United Nations Development Programme (UNDP), the World Bank and a number of international donors. New enrolments in 1989 rose by 11.8 per cent, against a projected 5 per cent, while education's share of the budget remained at its pre-reform level of 3 per cent.

Kenya embarked upon a progressive reform programme in the mid-1970s, which aimed, among other things, to give less privileged students, including girls and rural pupils, a better chance of attending secondary schools. It also hoped to provide students who would only complete the primary level with skills more relevant to their future needs. Evaluations in 1980 and 1981 showed a marked improvement in students' examination results.

In 1990, the nine countries of the Sahelian region — Burkina Faso, Cape Verde, Chad, the Gambia, Guinea-Bissau, Mali, Mauritania, Niger and Senegal — decided, for the first time, to review their future education development prospects as a group. These countries have the least developed education systems in the world, with average primary enrolments of 52 per cent and literacy rates of 25 per cent. Their Ministers of Education and key officials from the Ministries of Finance and Planning met in Bamako, Mali, to discuss common constraints on national education programmes. They have agreed to follow up with workshops and technical meetings aimed at developing economies of scale for educational research and institution building throughout the Sahel.

In Mozambique, where schools and teachers were the targets of bandits sponsored by the South African Government from 1982 onwards, more than 2,000 rural primary schools were destroyed, effectively denying education to some 500,000 children. In the province of Nampula, the Governor reported in 1989 that the war waged on Mozambique had forced the closing of 35 per cent of the school network. Bandits also killed 75 teachers.

Damage to Mozambique's education infrastructure has left two thirds of the country's 2 million primary school age children without schooling, and UNICEF has asked for some US$4 million to help rebuild schools and develop special education

programmes catering to the needs of at least 500,000 children who have been traumatized by their war experiences.

Where governmental and other resources are scarce, Mozambicans have taken the education of their children into their own hands, establishing informal schools or *escolinhas* under the supervision of young adults who have been trained with UNICEF assistance. These schools often operate in the courtyard of a house or under the shade of a tree. There are about 150 *escolinhas* at the present time, servicing the needs of about 20,000 children.

The girl child

Discrimination against women in many countries begins in childhood. From the moment of her birth, social and cultural attitudes conspire to give the girl child less than the family or society would provide for her brother. It is the boy child who usually receives the bulk of available resources, including food and parental attention, health care and education.

There is a deeply entrenched preference for sons in many societies. This encourages neglect and exploitation of the girl child and ultimately lowers the status of women.

It is extremely difficult for the girl child to outgrow the prejudices which surround her at birth. More often than not, the duties assigned to her as a young girl, and later in life, are undervalued. She is not paid for domestic or agricultural labour.

Childbearing and child care are regarded as social responsibilities. The girl child is condemned in many countries to early marriage and early motherhood. Girls marry under the age of 15; as many as 50 per cent of teenagers in some countries are or have been pregnant. As children bear children, their own chances of education, training and self-development are further constrained. The survival and care of their children become even more problematic. And when she works for wages, they are almost invariably less than would be paid to a boy or a man for the same output. One UNICEF study concluded that women in developing countries work twice as many hours as men for one tenth the income.

In East Africa, it is estimated that women spend up to 16 hours a day growing and preparing food, gathering fuel and water, and performing other household tasks as well as caring for children and members of the extended family. In Africa as a whole, women farmers are credited with 60 per cent of all agricultural work. Without child care services and appropriate technology, women share these arduous tasks with their girl children.

When women do find opportunities for cash income they are usually in the informal sector or in jobs with little status. In Nigeria, 94 per cent of street food vendors are women, and in Kenya, almost 80 per cent of women employed by the service sector of the economy are in the low wage bracket.

In the absence of education or other opportunities for advancement, the horizon for the girl child in Africa today looks much the same, if not worse, than it did to her mother. The profound economic crisis of the 1980s and the severe erosion of basic services caused by structural adjustment programmes have feminized the face of poverty in many communities. In some rural areas, up to 40 per cent of the households are headed by women, and for the first time in more than a decade maternal and infant

mortality rates are rising and school enrolments are declining. In Uganda, one third of mothers pay school fees which used to be paid by fathers.

The education of the girl child presents both a challenge and an opportunity for Africa. UNESCO recently counted 14 developing countries with female illiteracy rates of 80 per cent and above, and 10 of them were in Africa. No nation can afford to have such a large sector of its population disenfranchised and its human resources undeveloped in this way.

Experience has shown time and again that the education of the girl child and woman and equal opportunity for her advancement are indispensable, if not the key, to most development objectives. Little by little, Governments are beginning to count the cost of discrimination. Most of the developing world's farmers are women. They grow the crops, tend the livestock and collect fuel and water for the family. They make decisions affecting land use and the application of pesticides and fertilizers, and through each of these tasks they can have a major impact on productivity and the quality of the natural environment. As mothers, their knowledge of nutrition, basic health care and hygiene are key factors in child survival, which, in turn, influences the size of their families and population growth rates at large.

The needs of the girl child are gaining prominence on many international and national agendas. They were discussed at length at last year's World Conference on Education for All, and they form a part of the World Summit for Children Declaration and Plan of Action. The Convention on the Rights of the Child, which became international law in September 1990, endorses the principle that every child has the right to survival, protection and development, regardless of sex, and the African Charter on the Rights and Welfare of the Child, adopted by the Organization for African Unity, reinforces that position. These international provisions uphold the need to implement the Convention on the Elimination of all Forms of Discrimination Against Women with respect to the girl child.

UNICEF and other international organizations have moved progressively to integrate the special needs of women and the girl child into their programming. UNICEF-assisted programmes include not only infants and young children under age five, but also consider girls, adolescents and women of all ages, regardless of their maternal status.

African heads of State and Government are also paying increasing attention to these issues. Malawi, Morocco, Somalia, Togo and Uganda have commissioned studies on the needs of girl school drop-outs, pregnant adolescents, rural women, women farmers, female headed households and related questions such as women's access to credit and household food security. In Egypt, 73 village banks have established revolving funds to advance loans to women, and priority is being given to women heads of households. Ethiopia and Kenya have incorporated special objectives for women in their sectoral programmes, and the needs of working women have been added to a list of concerns being addressed in Burkina Faso, Mauritius, Sierra Leone and Tanzania.

The care of siblings is often the responsibility of the girl child — a duty which keeps many young girls out of school. UNICEF is supporting child-care facilities and pre-school programmes in several countries including Cape Verde, Maldives, Namibia, Togo and Tunisia.

It is too early to assess the impact of these responses. National resources are scarce, and the special needs of the girl child must compete with many other priorities. But positive shifts are discernible on a broad front, giving reason for hope that the tide can be turned and a real investment can be made in the development of the girl child and the future woman in Africa.

Food and nutrition

Although agricultural capacity to grow food has risen dramatically since the 1960s, food production in most African countries has been falling. And for many people in sub-Saharan Africa, 1991 will be a year of extraordinary hardship.

The United Nations Food and Agriculture Organization (FAO) reports [1] that 14 African countries face exceptional food shortages this year, and the World Food Programme (WFP) has warned that the emergency needs of sub-Saharan countries are likely to exceed those of the 1984-86 drought. WFP estimates that these countries will need at least 3.9 million tonnes of emergency food aid to cover the needs of more than 27 million people — most of them in Ethiopia, Mozambique and Sudan.

The ability of the international community to help is not in doubt. Global food stocks this year are at record levels. But even if relief stocks reach the countries in need, an emergency stockpile at the port of entry is no guarantee that hungry populations in the hinterlands will be fed. Poor communications, transportation and other distribution problems can hobble the best intentions.

The timing of assistance, as always, is critical. Even in the best of years, nutrition is wanting in much of Africa. Average per capita food production has been falling since the 1960s, and malnutrition has lowered people's physical stamina and resistance. On much of the continent, young and old live in a permanent state of high vulnerability to major disruptions in food supply, disease and infections.

Children are at greatest risk. Their survival and early physical and mental development are dependent on a balanced intake of nutrients from their diet. Even when food is abundant, there is a possibility that mothers will have neither the time to prepare good-quality meals and feed their children as often as necessary during the day, nor sufficient knowledge of nutrition and hygienic food preparation to safeguard their children's health. Infections can also reduce children's intake by depressing their appetite and by reducing the absorption and utilization of nutrients consumed.

It is estimated that 29 million African children, or about 25 per cent of the population under five years of age, are currently underweight. Poor nutrition has stunted the growth of 39 million (35 per cent), and 10 per cent show signs of wasting. Indeed, Africa has nearly one third of all the wasted children in the world. About 14 per cent of the children born this year will be of low birth weight — a condition usually associated with the poor nutritional state of pregnant women. In some families, it may be generations before cycles of hunger and poor development are broken.

[1] *Food Outlook* (March 1991)

Other nutritional hazards include iron deficiency anaemia and deficits of vitamin A and iodine. It is estimated that 56 per cent of children under five, some 44 per cent of women aged 15 to 49, and 63 per cent of pregnant women are anaemic.

Vitamin A deficiency is widespread, especially in the Sahel and south into Angola, Madagascar and Mozambique. It reduces immune responses to measles, respiratory diseases, diarrhoea and other life-threatening infectious disorders and can lead to nutritional blindness.

At least 30 million Africans suffer from goitre, endemic cretinism, impaired growth, and increased perinatal and infant mortality as a result of iodine deficiency, and another 60 million are estimated to be at similar risk.

Children in war and drought-affected areas are even more vulnerable this year. Between 40 and 60 per cent of Ethiopian children aged one to three years and 40 per cent of Mozambican children aged one to two years are reported to be malnourished.

While starvation from famine is a very real threat in many African communities this year, maternal and child mortality from malnutrition is usually the result of prolonged and interrelated deficiencies. Inadequate dietary intake and disease are the immediate causes of malnutrition. Dietary deficiencies might be caused by inadequate food supply or feeding practices. Death from disease might result from unsafe water supplies, inadequate child care or poor access to health services. A combination of these factors, including limited knowledge of dietary needs, basic hygiene or an awareness of simple life-saving remedies such as oral rehydration solutions against diarrhoeal dehydration, can also have a major influence on the capacity of children to survive in good times and in bad.

The UNICEF focus on sound nutrition in Africa is on the promotion of understanding at all levels of society of the causes of malnutrition, and on helping communities to assess and analyse their situation and respond appropriately. Community-based monitoring of children's growth is an important source of information for this process. Examples of activities that are supported by UNICEF range from improved maternity services and breast-feeding and weaning practices in Botswana, Côte d'Ivoire, Ethiopia, Kenya, Swaziland and Zimbabwe to the improvement of household food security in Angola, Botswana, Guinea, Madagascar, Malawi, Mozambique, Nigeria, Tanzania and Zambia, and the development of health facilities and child care in all countries. Vitamin A and mineral supplements are provided in many countries. UNICEF supports nutrition surveillance programmes with FAO and the World Health Organization (WHO) to identify vulnerable population groups. A surveillance workshop in Maputo, Mozambique, last year was attended by representatives from Angola, Cape Verde, Guinea-Bissau, Mozambique and Zaire.

UNICEF, together with FAO and WHO, supports the African Regional Task Force on Food and Nutrition which has declared the 1990s to be an international decade on food and nutrition for Africa. At a meeting the Task Force accepted a strategy of assessment, analysis and action as key to improving nutrition in Africa during this decade, with emphasis on community participation, information systems, human resource development, advocacy and social mobilization, empowerment of women, mobilization of resources, and inter-agency and intersectoral coordination.

Water supply and sanitation

Unsafe water supplies and insanitary means of waste disposal are elements of a vicious cycle which poses a continuing threat to child health and survival in much of Africa today.

Diarrhoeal diseases, related to inadequate water supplies and sanitation services, and poor personal hygiene severely debilitate children, leaving them especially vulnerable to malnutrition and infections. However, recent studies by the United States Agency for International Development (USAID) and the World Health Organization (WHO) have shown that the provision of improved water supply and sanitation services can reduce the prevalence of diseases in a community by at least 26 per cent. And experience confirms the importance of linking water supply and sanitation programmes with health, nutritional and socio-economic considerations for the overall betterment of child health and development throughout the continent.

There is a strong correlation between accessible water supplies and nutrition. In communities with inadequate water supplies, women and children spend inordinate amounts of time carting water from distant sources. Precious calories and energy are wasted in this daily pursuit.

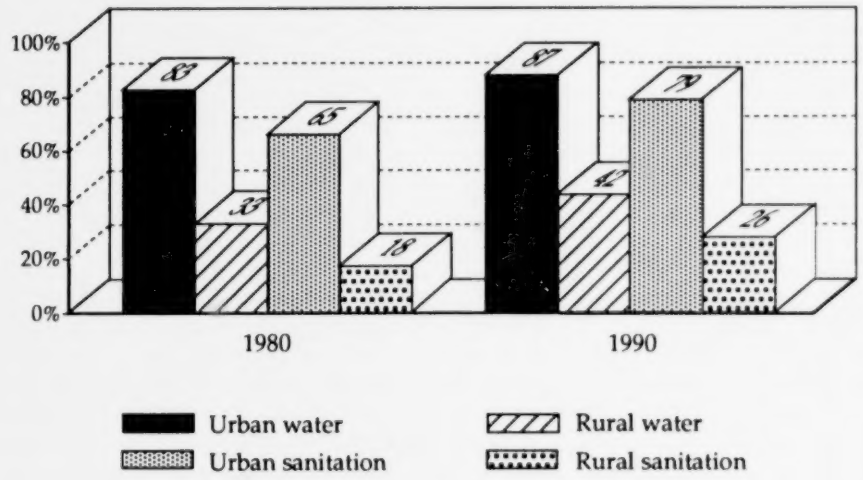
One study in Sudan found that an easily accessible water source saved women about six hours a day of fetching and carrying — time which could be devoted to other tasks including food processing or income-earning occupations. Accessible water supplies also eased the burden on children, and young girls in particular, who might spend their time more productively at school.

Inadequate water supply and sanitation encourage the transmission of infectious and parasitic diseases including: diarrhoea, typhoid, trachoma, intestinal worms and skin diseases. In parts of Africa, water-borne diseases including schistosomiasis and dracunculiasis (guinea worm disease) are rampant. In sub-Saharan Africa, 19 countries are affected by guinea worm disease, which incapacitates victims for as much as three months of the year. A 1987 study in four states of Nigeria estimated that the value of labour lost to guinea worm during the annual rice harvest was about US$20 million. Eradication efforts have cut the incidence of guinea worm disease in Nigeria by 39 per cent, or some 390,000 cases, in the past year.

The International Drinking Water Supply and Sanitation Decade (1981-1990) did not achieve its goal of 'Water and Sanitation for All'. Its objectives were largely overwhelmed by new demands created by population growth, and hampered by funding limitations. Other constraints included a shortage of trained personnel for the installation, operation, management and maintenance of water supply and sanitation systems.

Despite these limitations, however, access to safe drinking water did increase in urban areas of Africa from 83 per cent of the population to 87 per cent, and in rural areas from 33 per cent to 42 per cent. Sanitation coverage levels increased from 65 per cent to 79 per cent for urban areas, and from 18 per cent to 26 per cent for rural areas.

Water and Sanitation Decade performance: Africa



Source: WHO estimates

The challenge for most nations attempting to meet their water and sanitation goals has been to find ways of doing more with less. It was obvious, given the urgent needs of most African nations at the beginning of the Water and Sanitation Decade, that communities could not afford to wait until resources were available for large-scale dam construction and other water supply systems, similar to those serving households in the industrialized world. In addition to the cost of such infrastructure, the dispersal of populations in small communities, separated by vast distances, ruled out economies of scale which had worked in other regions. For the near future at least, the maintenance of centralized systems, with pumping stations and water mains supplying door-to-door services, was considered impractical for all but the large urban centres.

The focus in much of Africa, therefore, has been on the development of self-sustaining community-based water supply systems, such as handpump-equipped boreholes, protected dug wells or springs and gravity-fed systems, and household excreta disposal using basic technologies such as improved pit latrines. The improved pit latrine has become the most popular technology for sanitation in rural and small urban communities of Africa. Malawi, Sierra Leone, Sudan, Tanzania and Uganda are attempting to strengthen their programmes for sanitation by broadening the scope to include attention to waste disposal, personal hygiene and household cleanliness.

Among the countries actively pursuing community-based strategies to improve water supply and sanitation are: Burkina Faso, Burundi, Cape Verde, Ethiopia, Ghana,

Guinea-Bissau, Malawi, Mozambique, Niger, Nigeria, Somalia, Sudan and Uganda. Committees have been formed to manage their systems' maintenance, and in Sudan, 800 villages have established five-member committees, with at least one woman member on each.

Recent reports from water project sites in Benin, Egypt, Sudan and Uganda indicate that the training of women as caretakers for community water supply systems has been very successful. Reports also indicate an overall improvement in the percentage of functioning water systems at the community level — a trend which can be attributed to the involvement of communities in their own water supply management through water committees which include women in the areas of operation and maintenance.

Water supply systems for rural and small urban communities have relied heavily on handpump technologies, which have proved to be very successful when adapted to local conditions. However, an improved water supply is only the first stage of the process towards better hygiene practices and the reduction of diseases. There is a clear need in Africa to pay much more attention to changes in hygiene behaviour, which can follow improvements in water supply and excreta disposal facilities. One way of addressing this question is through the integration of programmes related to water supply, sanitation and hygiene education — an approach currently being pursued strongly by Nigeria and Uganda.

Another approach is through linkages with diarrhoeal disease control programmes. Burundi, Cape Verde, Mali, Sierra Leone, Sudan and Tanzania have made progress in this area.

In recent years Governments throughout Africa have approached the need for accelerated water and sanitation coverage with a renewed sense of urgency. And at a 'Global Consultation on Safe Water and Sanitation for the 1990s', held in New Delhi last September, African delegates strongly endorsed a proposal to speed the provision of these basic services to low-income rural and urban populations in particular.

Urbanization

Rapid urbanization is transforming the horizon for millions of African children. While most countries in the region are still predominantly rural, urban populations have been growing at a much faster rate than those in the countryside, challenging Governments to provide adequate services for those who believe a better future can be found in towns and cities.

The number of Africans living in urban areas could double between 1985 and the year 2000. By the year 2020, there are likely to be 30 cities in sub-Saharan Africa with more than 1 million inhabitants. Several are expected to have more than 10 million.[1] Less than half this growth will be due to natural increase.

In the past, urban dwellers in many African countries benefited from government-subsidized investments in infrastructure and the development of modern enterprises which provided new employment opportunities, but waves of new immigrants have overwhelmed basic services throughout the region, leaving many of the newcomers more vulnerable to hardship and poverty than ever before. The economic downturn of the 1980s and a squeeze on social spending have meant that many, if not most, new arrivals must contend with the absence of health care, water and sewerage systems, garbage disposal, electricity and other services.

In cities such as Nairobi, Dar-es-Salaam, Dakar, Nouakchott, Lusaka, Lagos and Kinshasa, where populations grew more than sevenfold between 1950 and 1980, the strain has been extraordinary. In Nairobi, capital spending on water and sewerage fell from US$28 per capita in 1981 to US$2.50 in 1987, and maintenance spending on these services declined from US$7.30 to US$2.30. In Dar-es-Salaam, per capita spending on urban services fell by 11 per cent a year between 1978 and 1987. In Dakar, in the early 1980s, only 28 per cent of urban households had piped water connections. About 68 per cent of the urban population relied on public standpipes for water, and in one community there was only one standpipe for every 1,500 persons.[2]

This extreme pressure on urban services has placed families and children, in particular, under acute stress. Only one in four job-seekers can find employment in Côte d'Ivoire, ensuring that the vast majority, including women, must try to find a niche in the informal economy. Unless they have friends and relatives already established in the community, these new arrivals must find shelter on the fringes of the city in marginal and often illegal squatter settlements where basic amenities, such as safe water supplies, are only available at exorbitant prices.

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[1] World Bank [2] *Human Development Report 1990* (UNDP)

A UNICEF survey in Nouakchott found that a 200-litre barrel of water that cost about US$0.75 near the city centre cost between US$2 and US$3 on the outskirts where the poor were living. In a shanty town in Abidjan, the cost of water was 10 times higher than that in established residential areas. It was not surprising that in Nouakchott in 1987 the infant mortality rate in the encampments occupied by new city dwellers was almost twice the national average.

Disparities have been noted in Abidjan where communities near local hospitals have a ratio of one doctor for every 700-800 inhabitants. In the 'popular' areas inhabited by the new urban poor, the ratio is one physician for every 77,000-88,000 residents. For those who have made the transition from rural to urban living, the harsh reality for many is that child mortality in their new homes is higher than in the rural countryside they left behind.

Urbanization *per se* is not bad, however. Cities and national capitals, in particular, are very often the main engines for modernization and national growth. They are usually at the hub of transportation and communications, they house the main centres of learning and Government, and are showcases for national progress measured in terms of infrastructure, basic services and prosperity. Unfortunately, most of the region's major cities have been swamped by unmanageable influxes of people in search of modern lifestyles or refuge from natural and other disasters in the hinterlands. The desperation of their struggle to rise above acute poverty has tended to obscure the reality that cities can also be centres of affluence and opportunity, for the young in particular.

One of the principal challenges facing heads of State and Government in Africa today is to manage their cities better and create secure, healthy environments supportive of their inhabitants' struggle for prosperity.

One response to that challenge, in Ethiopia, has been the formation of an International Coordinating Committee for Welfare and Development (ICC). ICC was established in 1977 to address poverty in Addis Ababa, where 79 per cent of the population lived in low-income settlements under conditions of great deprivation.

UNICEF and a group of other United Nations agencies, international bodies and NGOs joined forces with a new municipal government known as the Central Urban Dwellers Association. The city was organized under 284 urban dwellers associations known as *kebeles* which were given broad responsibility for managing neighbourhood affairs and social development programmes. Since then, UNICEF has channelled all its assistance to the urban poor through ICC in coordination with the Government and other international organizations. All ICC activities demand full community participation in all phases of a programme's development and implementation — an approach that has saved time, safeguarded against the waste of resources through duplicated efforts and assured the cooperation of the communities which ultimately run and benefit from the infrastructure created.

Since 1977 ICC and the communities under the Central Urban Dwellers Association have developed more than 86 child-care centres serving almost 10,000 children under six years of age, and 41 day-care centres. Training is being provided for 20 new day-care instructors a year. The centres are supplied with educational and recreational materials, and local production of these materials has replaced the need for imports. Small-scale poultry farms and market gardens have been set up and in one 12-month period an ICC programme provided nutrition and supplementary feeding for 25,000 children and 12,000 lactating mothers.

Communities are actively involved at all stages, from the initial formulation of requests for assistance to the contribution of certain materials, labour and funds.

Children and AIDS

AIDS and a rapidly increasing case-load of adults and children infected with the human immunodeficiency virus (HIV) are tearing at the social and economic fabric of Africa.

A UNICEF survey of AIDS in 10 seriously affected African nations last year — Burundi, Central African Republic, Congo, Kenya, Malawi, Rwanda, Tanzania, Uganda, Zaire and Zambia — confirmed the profound impact of an epidemic that is overwhelming health care facilities as well as traditional support systems which would normally buffer the pain of sickness and death in African communities.

Among the grim findings:

▲ AIDS has already become the leading cause of death in at least one African city (Abidjan), and rates of HIV infection among the adult populations of cities such as Kampala (Uganda), Kigali (Rwanda) and Bujumbura (Burundi) are approaching 30 per cent.

▲ By the end of this decade, between 1.5 and 2.9 million women will have died from AIDS in East and Central Africa. Up to 30 per cent of the women of reproductive age in some African cities are currently infected with the virus and have a one-in-three chance of passing it to their newborn children.

▲ Adult deaths from AIDS are expected to produce between 5 and 10 million orphans by the year 2000 in East and Central Africa, and between 6 and 11 per cent of all children under the age of 15 could be orphaned by the death of one or both parents from AIDS.

▲ One in every 10 people infected with AIDS in East and Central Africa today is a child under five years of age, and according to the World Health Organization (WHO), the disease is fast becoming the leading cause of hospital admissions and visits to paediatric clinics. It is estimated that by next year (1992), 1 million African children will have been born with HIV infection and that 600,000 will have developed AIDS-related illnesses and will die before age five. WHO predicts that in some African cities, AIDS will bring a 50 per cent increase in infant and child mortality within the decade.

The UNICEF survey also confirmed the broad reach of AIDS infection which now threatens rich and poor, professionals and illiterates living in rural as well as urban areas.

The principal means of transmission of HIV in adults is through sexual contact and blood transfusions. Infected husbands are passing the disease to wives who, in turn, may pass it to sons and daughters before birth. Few people in Africa have access to HIV testing facilities, and, as long as the vast majority of those infected remain unaware of

their potential to spread the disease and fail to take precautions to make sexual intercourse safer, transmission continues silently and unabated.

HIV-infected infants develop AIDS-related illnesses more rapidly than infected adults, and the death of an infant or small child from AIDS is often a family's first warning that the mother and father might also carry the virus. Without a cure and with little, if any, medical care to relieve AIDS-related illnesses, the bereaved parents must confront the near-certainty of their own impending deaths and the prospect that any other children they might have will be orphaned.

For growing numbers of the elderly, AIDS has been doubly cruel. It has robbed them of adult children who are their main source of support in old age and left them unexpectedly with the need to support orphaned grandchildren. It is becoming increasingly common in pockets of Africa to find elderly women burdened by the arrival of six, eight or more grandchildren who have no one else to protect them.

This traumatic overload of orphans and the stigma which often accompanies AIDS present a double challenge for Africa — that of creating new support systems for communities with large orphan populations and long-term child care for situations in which traditional structures are no longer able to cope. For many communities, this moment of desperation has already arrived. AIDS is impacting heavily on the continent at a time when economic adjustment programmes have forced Governments to reduce essential services, including health care. It is sapping the labour market of manual workers and professionals who are at the peak of their productive lives. Evidence of that loss is already visible in declining household food security and the deaths of young orphaned children from causes unrelated to AIDS infection. Older orphans are at high risk of becoming rural or urban street children in environments that expose them to HIV infection through the need to exchange sex for their daily survival.

UNICEF is supporting a consortium of non-governmental organizations that are working with AIDS orphans in Uganda to develop long-term strategies to identify, monitor and support the needs of this rapidly growing group of children at risk.

Although various treatments have been developed for AIDS-related illnesses in the industrialized world, they are neither practicable nor affordable in Africa at the present time. Nevertheless, there is much that can be done to contain the spread of infection by:

- AIDS-prevention education;
- improving the safety of national blood supplies;
- increasing the availability of condoms;
- improving infection control procedures in health care settings.

UNICEF is a major contributor, with WHO, to international efforts to prevent and control AIDS and is supporting AIDS-education programmes in all affected African countries. It supports a home-based care programme that trains volunteers to help AIDS-affected women in Zaire and is involved in Ugandan programmes that have become models for the rest of the continent.

The Ugandan Government has recognized that an essential step towards curbing the epidemic is to educate young people about AIDS and means of preventing it, before they become sexually active. The Government is committed to the introduction of AIDS prevention to the curricula of all primary and secondary schools, and UNICEF is helping

to develop appropriate courses and teaching materials. It is also helping to train health educators to show women how to protect themselves and thereby safeguard against mother-to-child transmission.

These efforts are aimed at fundamental changes in sexual behaviour in Africa, and results are difficult to evaluate at this early stage. However, accurate information about the spread of the virus is being disseminated, and this knowledge could ultimately change the course of the epidemic in Uganda and other countries that are interested in duplicating AIDS-prevention programmes.

Mobilizing for immunization in Sierra Leone

Freetown, Sierra Leone: It is Sunday in Scotland Street, a typically poor narrow road running downhill towards the harbour. Dilapidated old houses with rusted iron roofs rise on either side of the street, above culverts filled with garbage and stagnant water. There is barely room for the bus to manoeuvre, but the driver manages to negotiate a tight corner at the bottom and pull up in front of a large white van.

"*Marklate*, come and bring your children for *marklate*", cries a voice over the van's loudspeaker. "*Marklate* protects your children against polio, whooping cough, measles, tuberculosis, tetanus and diphtheria." The message is in Krio, the local lingua franca. *Marklate* means immunization.

The voice from the van — a mobile vaccination clinic — belongs to a representative of the health education department of the Ministry of Health who has come to this part of town with women from Sierra Leone's Islamic Action Group (ISLAG) to promote child survival and development messages. Haja Aisha Sasso and other women from ISLAG descend from the bus and take over the microphone. They repeat the messages in Temne, Mende, Fula, Mandingo and other languages urging mothers to bring their babies to the van for vaccinations. A young boy also takes the microphone and addresses children who might have younger brothers and sisters in need of vaccination.

Gradually, mothers and older brothers and sisters appear with babies on their backs, in their arms or on their hips. Curious onlookers gather, and as the vaccination session gets under way the children's wails grow louder. Before long a number of young men also arrive on the scene wearing special bonnets and carrying musical instruments. Calling themselves the 'Freetown Players', they volunteer their time to roam the streets like troubadours, singing the praises of immunization and oral rehydration for young children.

"It is not easy to persuade people", Haja Aisha explains. "The men have heard the rumour that the anti-tetanus vaccine for women makes them infertile. We have to convince them this is not true." The women are also trying to counter recent talk among young women in Freetown that breast-feeding will spoil their breasts. "We particularly want to have Muslim women trained so that they can teach the girls and women about proper child care", says Haja Aisha.

The message is apparently getting through. In 1987, Sierra Leone had one of the world's highest under-five infant mortality rates, with one in every four children dying before the fifth birthday. Since then, however, the immunization coverage against the six main killer diseases for children in their first 12 months of life has soared from about 6 per cent to almost 70 per cent.

A major health improvement

Linakeng, Lesotho: A visitor to this small rural village is immediately struck by at least two features of the place: the neat uniformity of its mud brick and straw housing and the absence of working males. It is mainly the women who keep the village going, who till the fields and who manage day-to-day affairs. In most households, at least one able-bodied man is away in South Africa, working in the mines.

Mpho Makhetla, like the majority of her friends and neighbours, accepts double duty as mother and household custodian as a fact of life. She has six children, three of them under five years of age, and she sees her husband just three times a year for short intervals. Her mother helps to care for the children while she works in the fields, and when money is short Mpho brews a little beer for sale. Most of her wheat and corn harvest is for home consumption.

Although Mpho is the effective head of the household for most of the year, her decision-making is ultimately limited by her husband's wishes. She receives small bank remittances while he is away but most of his earnings travel home with him on vacation.

For the past year, Mpho has been quietly campaigning by letter to have some of those earnings reserved for a major home improvement — a simple VIP (ventilated improved pit) latrine. About half the families in Linakeng have one, and there is general agreement in the village that their children are healthier as a result. Moreover, the publicity given to pit latrines in Lesotho has made them something of a status symbol, and Mpho has been urging her husband to take up the project on his next visit.

The investment in a latrine is significant — as much as US$150 in a country with an average income of US$370 a year — but a rural sanitation programme introduced by UNDP, UNICEF and the World Bank in 1983 lends money to families for two years at an annual interest rate of 11 per cent, and Mpho is confident her husband will see the merit of the project.

The construction of VIP latrines in Linakeng and other villages in Lesotho is usually contracted through health clinics, which also advise on fair prices for the work. The sanitation programme provides training for local builders whose names are posted when they have completed the course. The latrines consist of a rectangular pit and four concrete slabs — two to cover the pit, one for the seat, and one to support the back wall. The exterior is usually constructed from local materials.

Given a shortage of male workers in Lesotho it is not surprising perhaps that one in four of the builders is a woman, but Litoko Motebang, a former district health assistant responsible for the programme in Linakeng, says that women builders are also

less likely to drop out of the programme than men and are excellent communicators and sales agents for their products.

The rural sanitation programme has expanded steadily since its introduction seven years ago. It now has the additional support of British, Irish, Swiss and other bilateral agencies and is being implemented through the national Rural Development Department and the Ministry of Health. The programme is operating in eight of the nation's 10 districts where it focuses on villages like Linakeng which have already developed reliable water supply systems. Health assistants are employed by the programme not only to motivate villagers to purchase latrines but also to couple their use with better health and hygiene practices.

In Linakeng, the pubic health nurse at the village clinic has been concerned by the frequency of diarrhoea among Mpho's children, but she is encouraged by Mpho's determination to do something about it. The incidence of diarrhoeal illnesses in Linakeng has been cut by 25 per cent in those households with VIP latrines, and a recent study found that when better sanitation was combined with the use of greater quantities of water for personal hygiene, the diarrhoea rate could be lowered by a further 30 per cent. Water is pumped into Linakeng from hillside springs which assure villagers of at least 20 litres per person per day, so the stage is set for some rather significant health gains — provided that migrant male workers like Mpho's husband share their women's priorities.

Africa's AIDS orphans

Rakai, Uganda: "At 72 years of age Joanna Namatovu has two new families to take care of. Two of her sons have died of AIDS in the past two years, leaving her with two huts, two *shambas*, two absent daughters-in-law and two new sets of mouths to feed.

"On one side of the village are three tots ranging in age from 18 months to 6 years. Their mother left to pursue the possibility of remarriage in Tanzania. Across the ridge are five more children, the eldest of them 12 years old. Their mother is believed to be in Mbarara, married again, or about to be.

"Mrs. Namatovu needs blankets, bedding, food and clothing. More than that, she needs a rest from her struggle to feed eight grandchildren, a task in which she gets no help. She also needs some respite from the psychological burden of knowing she cannot provide school fees — the one thing which would protect the children against ignorance and despondency. She is fearful that a lack of opportunity might eventually cause them to become criminals or rebels.

"Emotionally, the children appear to be perfect candidates. Since their fathers died, they seem to have become more sullen and difficult to manage as each day passes. And yet, the scarred, tired face of their grandmother achieves a winsome, childlike quality as she teases us and laughs at our questions. She is sceptical that we can bring her any help at all."

When Dr. Susan S. Hunter wrote the above introduction to a report on the growing tragedy of Africa's AIDS orphans last year (1989), she was very much afraid that Joanna Namatovu was right. One in every four children in Joanna's village had lost at least one parent to AIDS, and many were in the care of guardians who were too old or too young to provide adequate food, clothing, shelter, care and protection. Moreover, their guardians had grown weary of researchers who counted victims but brought no relief.

"Residents of many of Uganda's districts are sick to death of being queried, questioned, poked, tested and probed", Dr. Hunter said. "They are tired of giving their time and privacy to researchers and of having their expectations raised with no resulting benefit."

Some months after completing her report for the international journal, *Social Science & Medicine*, Dr. Hunter was engaged as a consultant by the UNICEF office in Kampala to initiate a series of activities which would strengthen local and national support for Uganda's AIDS orphans.

The Kampala office had received US$280,000 from the new UNICEF Interregional AIDS Fund in June in response to a proposal to help develop the capacity of NGOs and

the Ministry of Relief and Social Rehabilitation to work together.

Among other things, this money is being used to:

▲ develop a national NGO association to promote community-based assistance to vulnerable children;

▲ help the Ministry plan, monitor and coordinate its activities. A permanent database is being established to help identify priorities which might be addressed through NGOs;

▲ help develop a cooperative NGO-UNICEF research programme which will identify community-based interventions for the nation's most vulnerable children and particularly those orphaned by AIDS. Current and planned research includes a community coping study and a nutrition and health evaluation of children in the two areas of Uganda most affected by AIDS.

The basic premise for these activities — the first of their kind in Africa — is that the problems faced by AIDS orphans are similar to those of many other children in especially difficult circumstances and should be addressed accordingly.

Government and other agencies in Uganda are anxious to avoid the stigmatization or isolation which AIDS orphans might experience if they were identified in a special category. The activities which Dr. Hunter is developing are therefore based, in part, on the previous experience of UNICEF in helping the orphans of Uganda's civil war.

Dr. Hunter's study for the Save the Children Fund (UK) estimated that 12.8 per cent of the children under age 18 in the Rakai District — some 26,000 children — had been orphaned by AIDS. The study predicted that the situation would worsen, and a number of politicians said they were afraid that traditional extended family support mechanisms would be overwhelmed by the needs of these children.

AIDS mortality among Uganda's adult population has risen steeply in the past five years, and the Save the Children study suggests there could be as many as 1.2 million orphans nation-wide – a number predicted to almost double in the early part of the next century.

This projection is in keeping with UNICEF projections on AIDS mortality figures for nine other sub-Saharan African countries, which suggest there could be as many as 5 million AIDS orphans in the region by the end of the current decade.

Uganda is the only country in the region which regularly reports on the prevalence of HIV infection and AIDS mortality, and it has also been the first to recognize the needs of its burgeoning population of orphans. In that sense, it has a head start on its neighbours, although researchers note that statistical data is extremely limited. Under-enumeration in those villages visited by field workers ranges from 5 to 50 per cent, suggesting that studies have only covered the tip of an iceberg. UNICEF is hopeful, however, that the special activities now being developed in Uganda will provide a framework for action in neighbouring countries as well, as recognition of the problem grows.

"There have been some positive developments in Uganda", says Dr. Hunter. "Things are happening very quickly. Many NGOs have moved into Rakai and other districts since UNICEF called attention to the needs, and there is a deep spirit of cooperation which will ensure that people get the help they need."

Just how soon they will get that help, however, is a question neither Dr. Hunter nor her colleagues in Kampala can answer. There are few resources available, and those in need cannot afford to wait.

Joanna Namatovu and other elders in her small village explained their situation to Dr. Hunter in this way: "From Friday to Sunday we go to funerals. We work on Monday to pay for the barkcloth (Uganda's traditional shroud), then go to another funeral on Tuesday. Wednesday and Thursday we work. On Friday it starts all over again."

Mobilizing Tunisia

Sidi Bou Said, Tunisia: The walls of this traditional Tunisian village have been whitewashed and unblemished since the mid-19th century. Picture them ablaze with birds of every colour — folkloric symbols of mother and child. Think of the old city of Medina, haunted by nightmarish puppets (depicting the six main child killer diseases) being chased through the streets by a ghoulish blue hand brandishing a syringe. Tunisians, it seems, will stop at nothing to shock and cajole their countrymen into vaccinating children, and the approach has paid off handsomely. Recent surveys show that Tunisia has achieved one of the highest immunization rates on the African continent and one of the best health performance records in the developing world at large.

In the wake of two very successful national immunization days in 1987 and 1988, Tunisia's mortality rate for children under five years of age fell from 184 per 1,000 live births in 1966 to 66 per 1,000 in 1988. Over the same period, infant mortality declined from 153 to 51 per 1,000. Coverage for children under 12 months of age against the six main childhood killer diseases currently stands at 99 per cent for tuberculosis, and 92 per cent for diphtheria, whooping cough, tetanus, measles and polio.

Several factors have catalysed this remarkable achievement. They include:

▲ a high level of political commitment to child health;

▲ a relatively high literacy rate. Almost all boys and 89 per cent of girls are enrolled in primary school;

▲ a broadly based medical infrastructure (an estimated 90 per cent of children have access to health services);

▲ strong public appreciation of health services (96 per cent of mothers surveyed recognize the importance of child immunization);

▲ the reach of television and radio media to about 90 per cent of the people.

The commitments of radio, television and print media, coupled with political support from the President downward, set the stage for the immunization of more than 1 million children and 500,000 women during the campaign periods. A variety of artists and actors gave their time for publicity events and news spots, and created a public mood of expectation for the unexpected. The campaigners sought to popularize immunization by demystifying it, and they succeeded.

On one occasion, UNICEF orchestrated a television gala evening at which prominent Tunisian artists, intellectuals, journalists, singers and sports figures gathered

under the emblem 'the Paintbrush and the Syringe' to help dispel the notion that immunization against diseases was something with which only health professionals should be involved. The message carried during this four-hour television marathon was that vaccinations and healthy children are everyone's concern. The President made highly visible 'surprise' visits to health centres to emphasize this basic message.

Tunisia does not have a tradition of street painting, but artists helped children paint a 400-foot child health mural in Sidi Bou Said. Many residents were shocked by this sudden splash of colour across their whitewashed urban landscape, but the message stuck. Mothers brought their children to be vaccinated on the appointed days, and the mission was accomplished.

Tunisia's experience since then has shown that this sudden enthusiasm was more than a flash in the pan. With its health infrastructure in place, the country has been able to sustain interest in the national vaccination programme and maintain almost 90 per cent immunization coverage for infants and small children against the main threats to their health.

Managing village water supply

Water, water everywhere, but is it fit to drink?

'No!' say women in the Central African Republic's northwestern savannah districts, such as Bossongoa.

Parasites carrying bilharzia and onchocerciasis abound in the waters of the Ouaham river, and in Bossongoa and its outlying villages women, until recently, found it preferable to leave home around 2 a.m. each day during the dry season and walk 10 to 15 km to collect water from a safer source. They would set out from home early to avoid the heat of the day and the swarms of bees which take over the water-holes soon after sunrise.

These daily treks are becoming shorter, however, with the arrival of handpumps in many of the villages. With UNICEF support, the district administration of Bossongoa installed 150 sturdy India Mark II handpumps between 1984 and 1987, and this year a second phase of the project is reaching communities farther afield.

A vital feature of the programme is that each community is involved in the financing of the pump installation and maintenance. Too many water supply programmes have failed in Africa because villagers have not understood the technology and have reverted to using unsafe water sources when their pumps have broken down.

In Bossongoa, a team leader and two repairmen train and equip local artisans to inspect the village pumps regularly and attend to all basic maintenance and repairs. Before a well is installed, however, a village must demonstrate its commitment to a sustainable source of safe water by raising 50,000 CFA (US$200) for well construction and the preparation of a sealed and enclosed area surrounding the pump. Once the installation is completed a second team, trained with UNICEF assistance, arrives to teach villagers how to use the pump properly and to protect the well and its perimeter against contamination.

Villagers are also taught basic principles of hygiene and are encouraged to cultivate gardens near the pump, irrigating the crops with overflow from the day's water collection. In addition, a community management committee is appointed to collect dues to cover maintenance and to guard the pump against misuse.

Careful management and maintenance is essential. It is not uncommon for a single pump in Bossongoa to service the needs of 500 families a day. Some villages appoint a volunteer or employ a person especially to oversee water collection and the behaviour of those who use the pump. In the village of Katanga II, a janitor unlocks the gate to the pump area at 5:30 a.m., tests the water, sweeps the perimeter and checks the

drain. Every woman who draws water from the well is required to bring a few rocks from a nearby quarry to help maintain the drainage channel, and no one is allowed to loiter and slow the traffic flow. To ensure that animal or other wastes are not tracked into the collection area, shoes must be removed and left at the gate. Sooty cooking pots are rejected, and the washing of clothes or the presence of small children are prohibited near the pump.

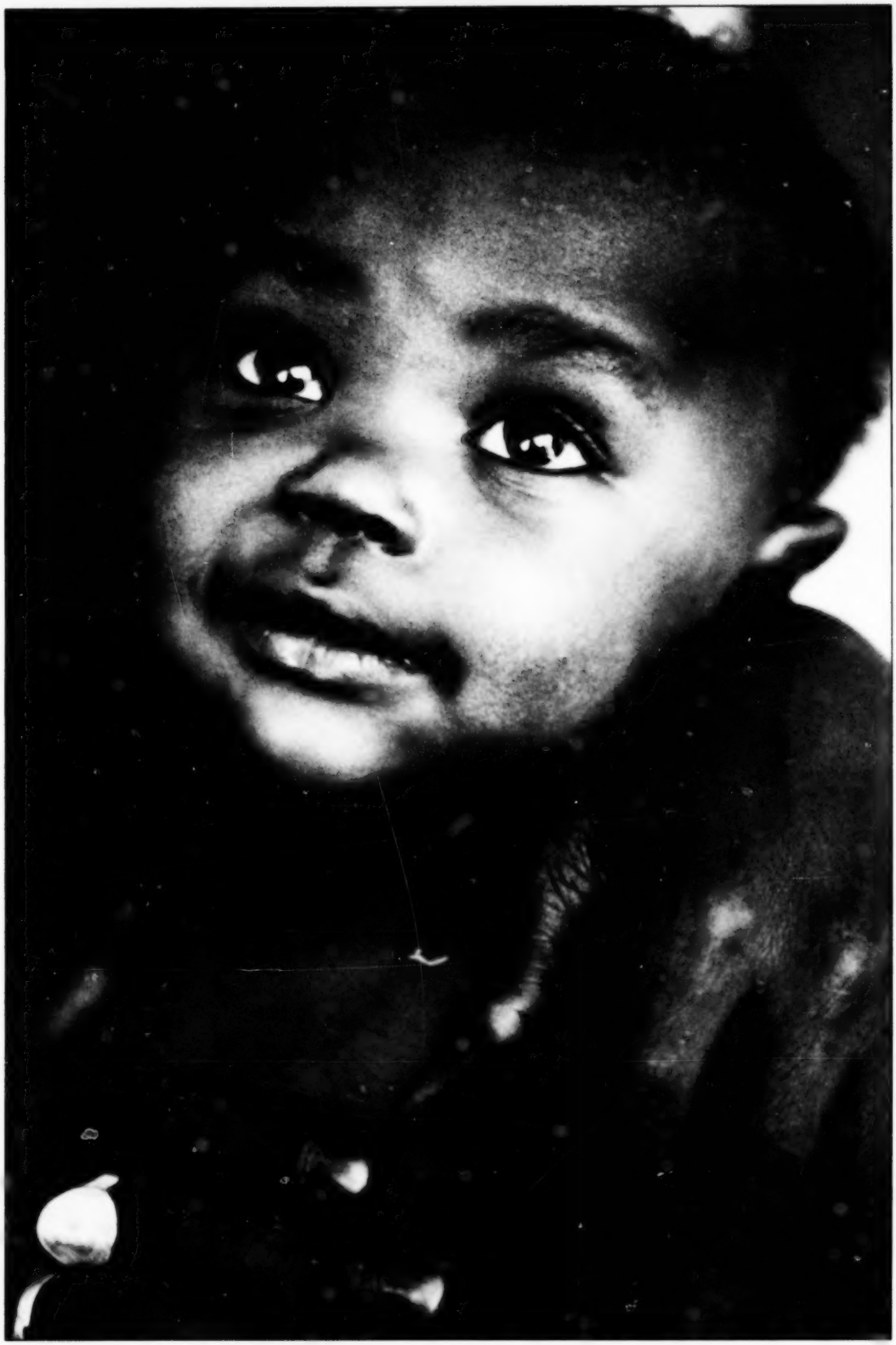
In a number of villages, UNICEF and the local management committees have attempted to make the pump the focal point for other development as well. In Kaga-Bandoro, efforts have been made to integrate pump management with health, hygiene, and nutrition education programmes, and one enterprising manager has introduced a water delivery system using a barrel mounted on a cart.

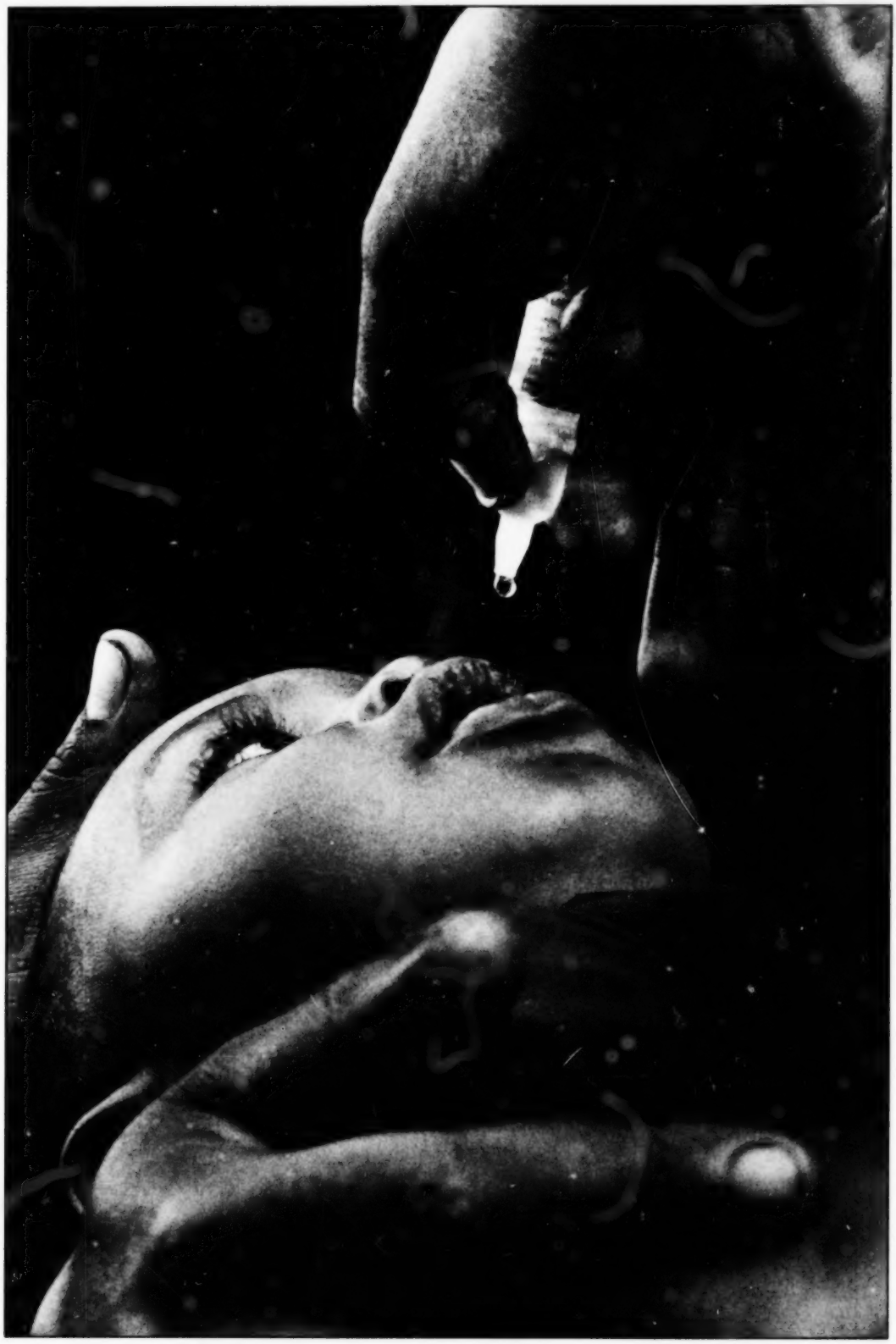
Without doubt, the most important improvement brought by the handpump programme has been in the health of children in villages where pumps have been installed. Both mothers and the nurses at the Bossongoa hospital report a significant reduction in the number of those being treated for bilharzia and intestinal disorders.

Children: Africa's Future

Declaring 16 June the Day of the African Child, the Organization of African Unity seeks to ensure that the economic crisis, war, drought and the AIDS tragedy do not wipe out the possibility of a hopeful future for the African child.

Credit must be given: UNICEF/C/91/ Roger Lemoyne





Today the Middle East and North Africa region has achieved its 80 per cent goal of universal child immunization, and coverage in sub-Saharan Africa — in spite of ongoing civil conflicts — has increased to between 58 per cent and 75 per cent for most vaccinations.

Credit must be given:
UNICEF/2306/88/
Bert Demmers

Children: Africa's Future

In Africa, protection against maternal and child mortality from malnutrition requires pre-natal care, promotion of breast-feeding and programmes that educate women in nutritionally sound practices, such as community garden food production.

Credit must be given:
UNICEF/4486C/90/
Lauren Goodsmith

Children: Africa's Future

UNICEF-assisted programmes increasingly address the special needs of war-traumatized children, as well as those of growing numbers of street children.

Credit must be given:
UNICEF/2840/88/
Jorgen Schytte

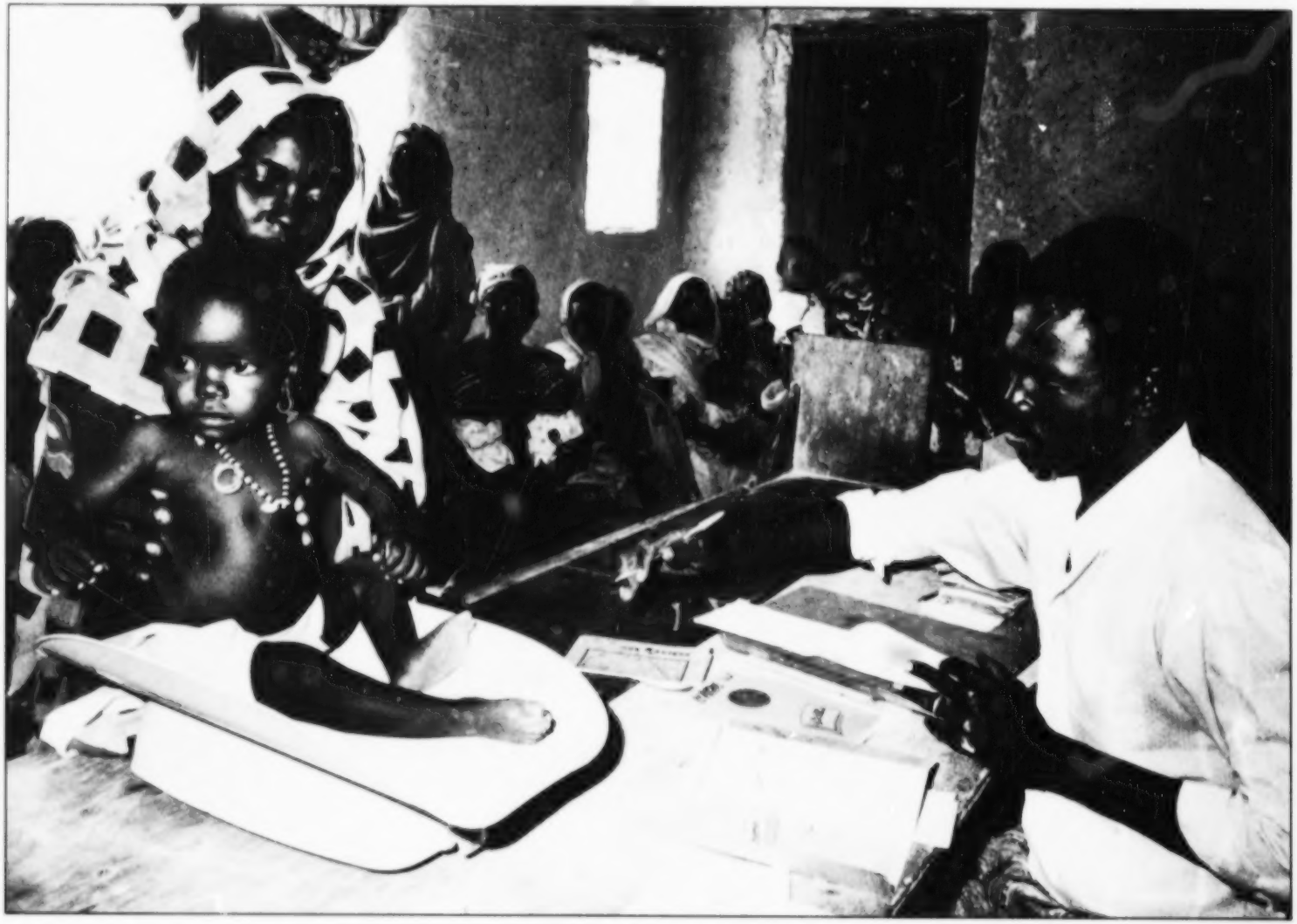
In African villages the provision of community handpumps guards against a host of water-borne diseases and promotes hygienic habits that protect against child diarrhoea.

Credit must be given:
UNICEF/3893/89/
Maggie Murray-Lee

Children: Africa's Future

A mother's knowledge of nutrition, basic health care and hygiene greatly determines her child's survival. UNICEF therefore targets the special needs of women, and of the girl child, in the interests of all children in the region.

Credit must be given: UNICEF/4404/90/ Maggie Murray-Lee



The Bamako Initiative strategy helps sustain primary health services by giving communities control over the management and finances of essential health components, such as the distribution of basic drugs.

Credit must be given:
UNICEF/4423/90/
Maggie Murray-Lee

Children: Africa's Future

Together with WHO and NGOs, UNICEF works with local governments to address the long-term issues of the growing AIDS tragedy in Africa, including support for integrating AIDS-prevention education into the school curriculum.

Credit must be given:
UNICEF/C/91/
Jorgen Schytte

Children: Africa's Future

African nations have sounded a powerful cry of hope for each child's future with their endorsement of the Convention on the Rights of the Child and their adoption of a special African Charter on the Rights and Welfare of the Child.

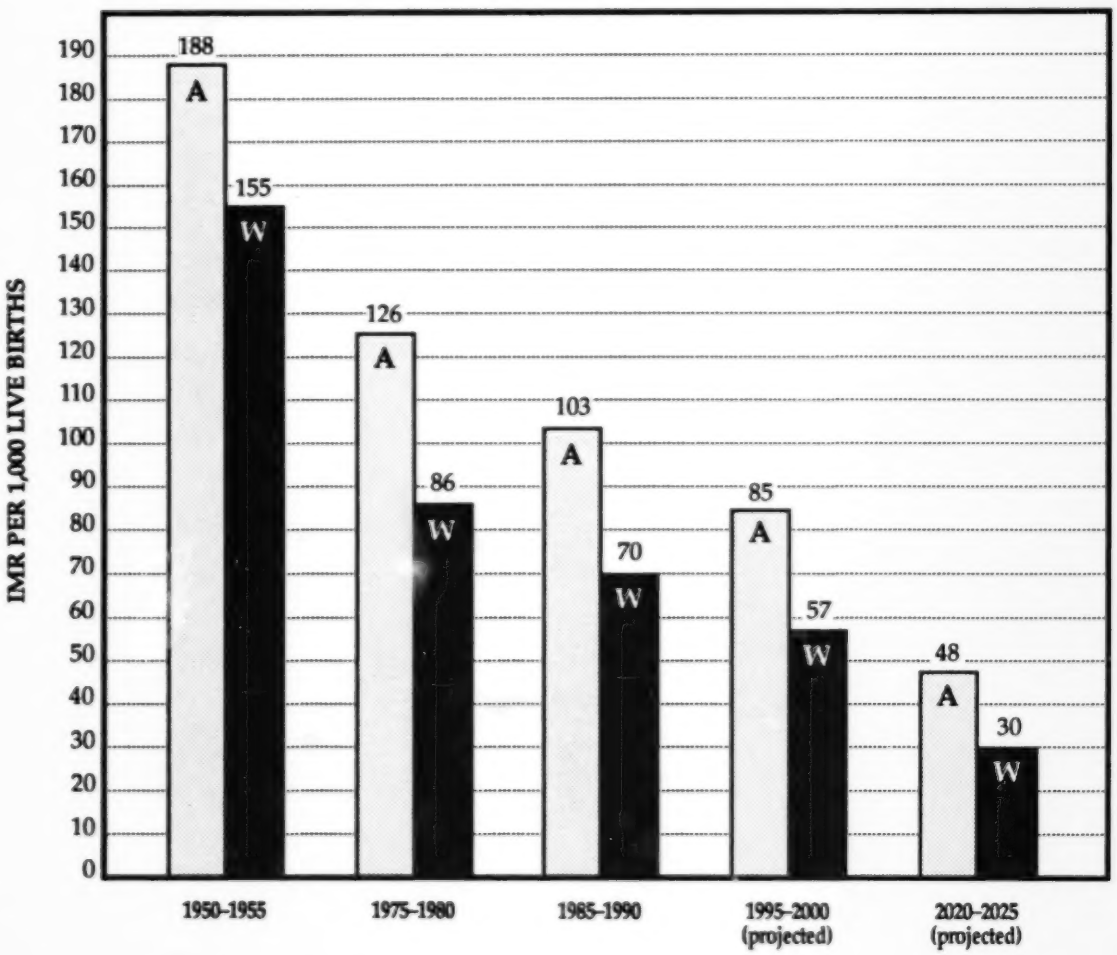
Credit must be given:
UNICEF/4437/90/
Maggie Murray-Lee

To address declining or stagnant government expenditures for education in Africa due to the economic crisis, nine countries in the Sahel agreed to coordinate resources to define educational priorities in their region.

Credit must be given:
UNICEF/2243/88/
Jorgen Schytte

Infant mortality rate (IMR)*

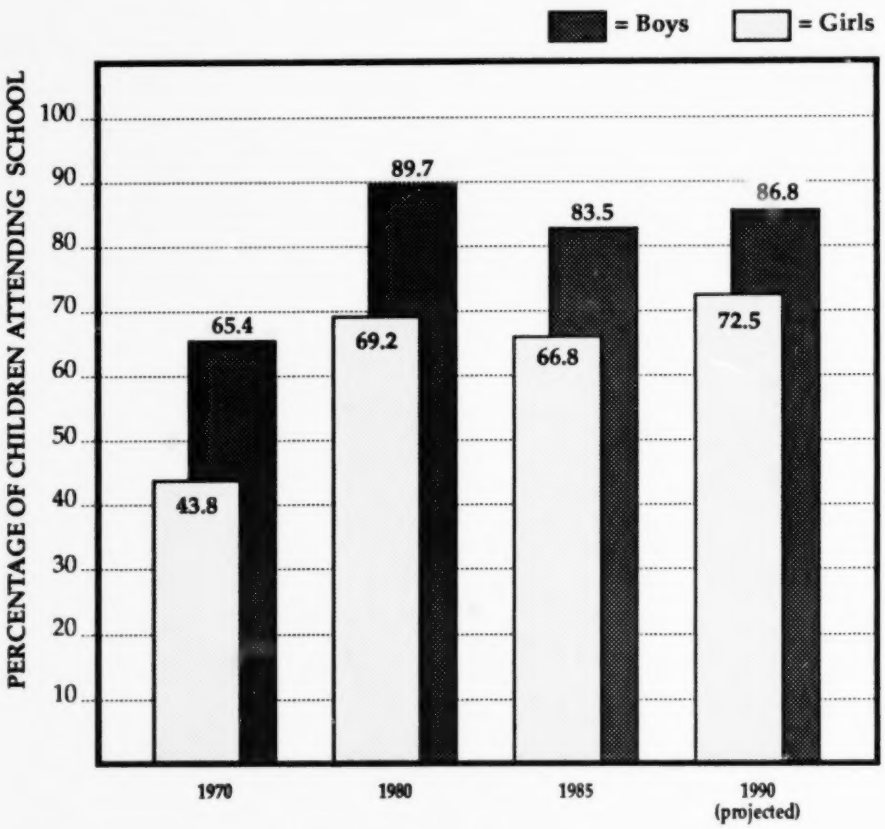
A = Africa
W = World (including Africa)



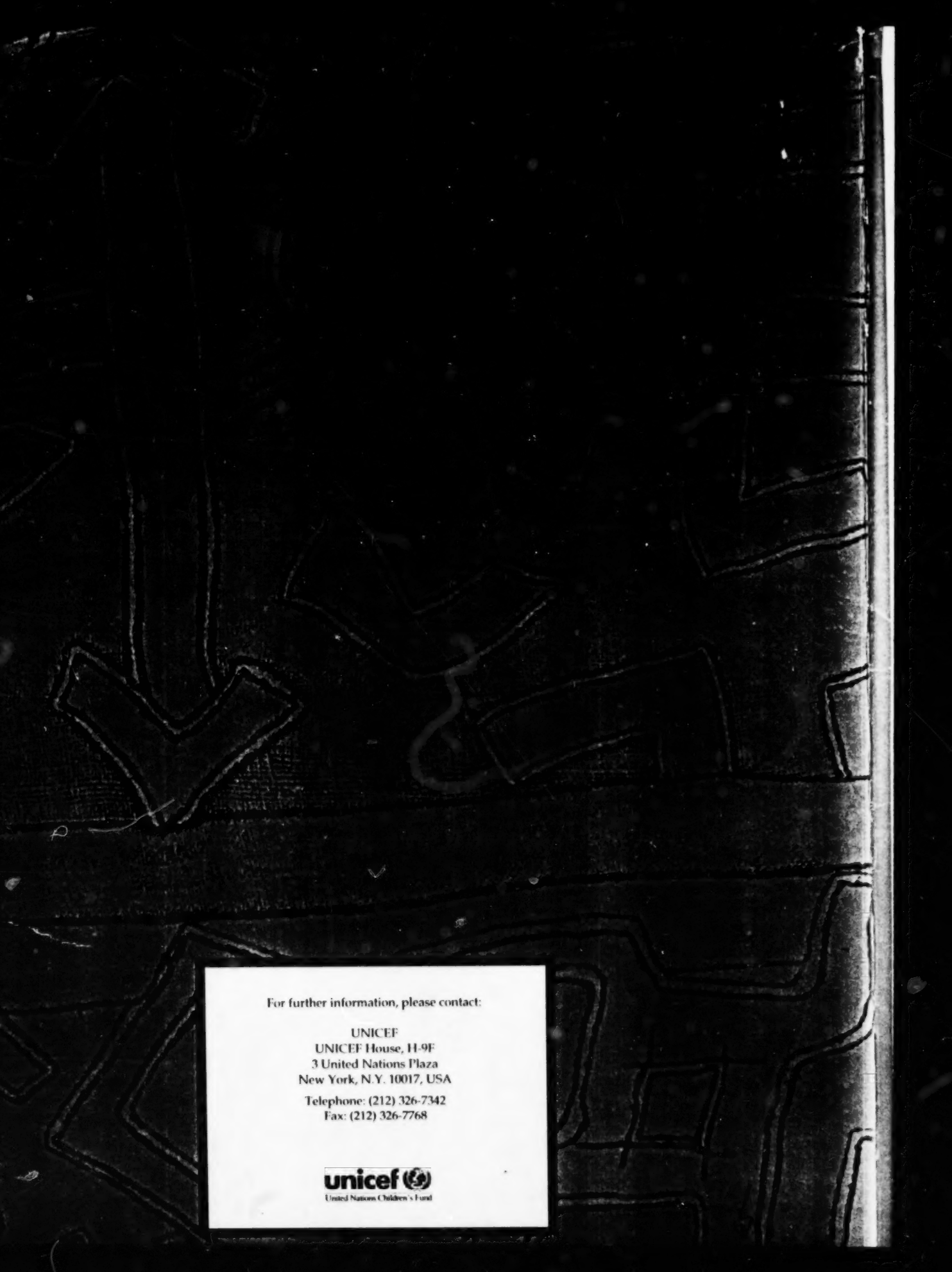
Source: *World Population Prospects*, United Nations, 1990

* Number of infants dying before their first birthday per 1,000 live births

Access to primary education, Africa



Source: *UNESCO Statistical Yearbook 1990*



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